BASIC PHYSIOPATHOLOGY OF GENERAL HEMATOLOGY

A SYNOPSIS OF HEMATOLOGY

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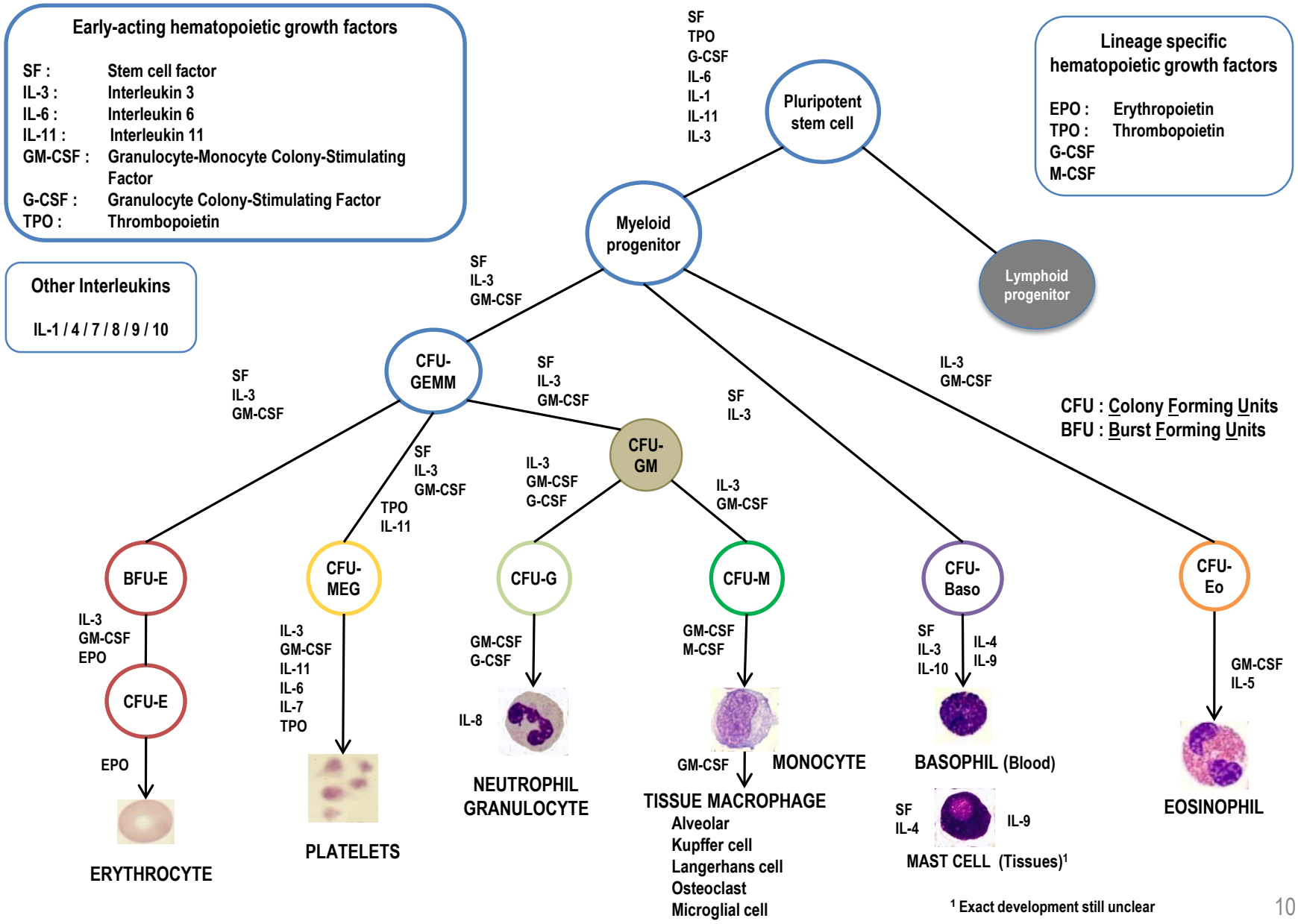
Part 1

RED BLOOD CELL DISORDERS

DIFFERENTIATION OF BLOOD CELLS



NORMAL RANGES IN HEMATOLOGY

	UNITS	MEN	WOMEN
HEMOGLOBIN[1] *(Hb)*	g / L	133 – 177	117 – 157
HEMATOCRIT[1] *(Hct)*	%	40 – 52	35 – 47
ERYTHROCYTES[1] *(Ery)*	T / L	4.4 – 5.8	3.8 – 5.2
MCV	fL	81 – 99	
MCH	pg	27 – 34	
MCHC	g / L	310 – 360	
RDW[2] *(Anisocytosis index)*	%	< 15	
RETICULOCYTES *(relative value)*	‰	5 – 15	
RETICULOCYTES *(absolute value)*	G / L	20 – 120	
LEUKOCYTES	G / L	4 – 10	
THROMBOCYTES / PLATELETS	G / L	150 – 350	

[1] Increased values with prolonged stay at high altitude
[2] RDW : Red cell distribution width

T / L : Tera / L = 10^{12} / L
G / L : Giga / L = 10^{9} / L
fL : Femtoliter = L^{-15}
pg : Picogram = g^{-12}

LCH-CHUV, 2015

COMPLEMENTARY INDICES *

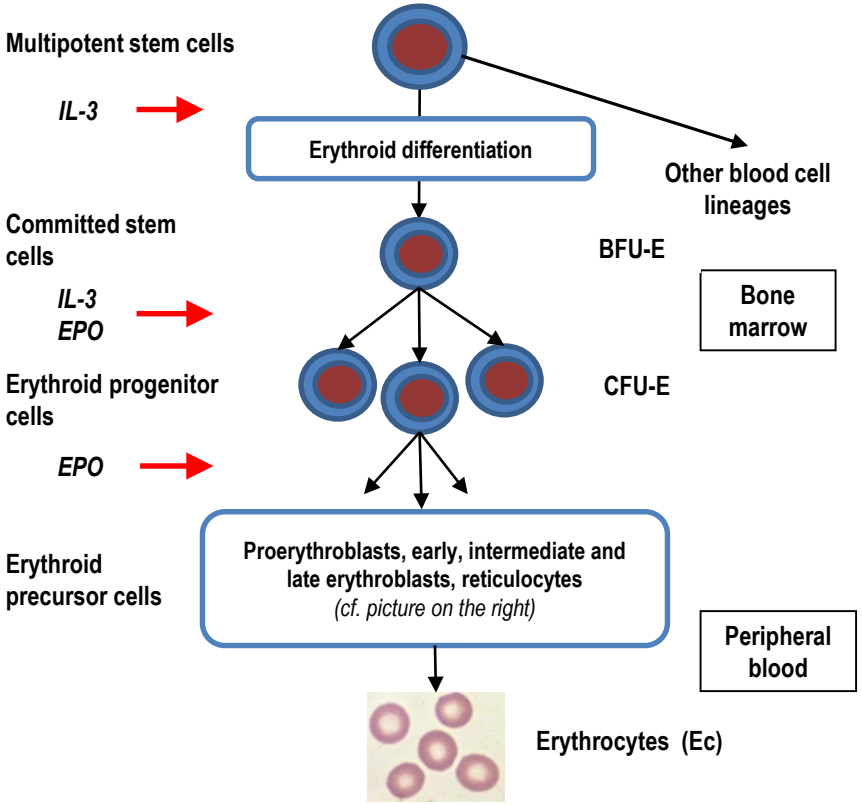
INDEX	UNIT	REFERENCE INTERVAL**
HYPO[3]	%	< 5.0
MCVr / MRV[4]	fL	104 - 120
CHr[5]	pg	28 - 33.5
IRF[6]	%	2.3 - 15.9
MPV[7]	fL	7 - 11.5
PDW[8]	%	9.0 - 13.0

* *Indices produced by hematological analyzers*

[3] HYPO : *Hypochromic RBC fraction*
[4] MCVr : *Mean Cellular Volume of reticulocytes* ** *or*
MRV : *Mean Reticulocyte Volume* **
[5] CHr : *Cellular Hemoglobin Content of reticulocytes* **
[6] IRF : *Immature Reticulocyte Fraction*
[7] MPV : *Mean Platelet Volume* **
[8] PDW : *Platelet Distribution Width* **

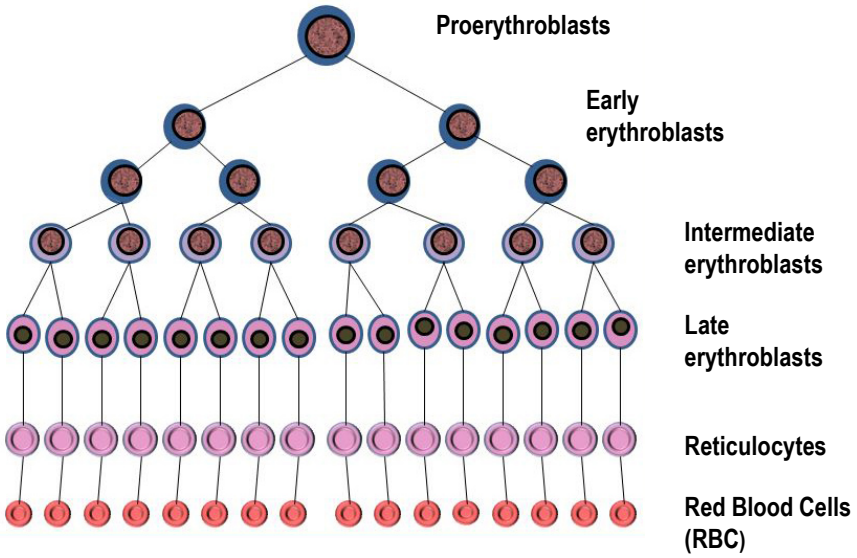
** These indices may vary depending on the type of analyzer and of preanalytical conditions

ERYTHROPOIESIS



BFU : Burst Forming Unit CFU : Colony Forming Unit

Classical schedule of erythropoiesis. Cytokines like Interleukin 3 (IL-3) act on stem cells and primitive BFU-E; Erythropoietin (Epo) acts on more mature BFU-E but principally on CFU-E and on the erythroblastic compartment



Amplification and maturation of the erythroid cell line from proerythroblasts to RBC

The mature red blood cell has extruded its nucleus
Apart from the **cell membrane,** its main component is **hemoglobin**, a complex protein in which the incorporation of iron (Fe^{++}) plays an essential role
Hemoglobin allows the **binding and transport of oxygen** from the pulmonary capillaries and its **release** to body tissues

EVALUATION OF ANEMIA

3 PARAMETERS

Hemoglobin (g / L)

Red blood cell count (T / L = 10^{12} / L)

Hematocrit (%)

DEFINITION OF ANEMIA (WHO 1997)	
AGE AND GENDER	HEMOGLOBIN (g / L)
Child (< 5 years)	< 100
Child (5 - 11 years)	< 115
Child (12 - 14 years)	< 120
Adult male	< 130
Adult female	< 120
Female (pregnancy)	< 110

3 INDICES

MCV : **Mean Corpuscular Volume** *(Hct / RBC) x 10 (fL)*

MCH : **Mean Corpuscular Hemoglobin** *Hb / RBC (pg)*

MCHC : **Mean Corpuscular Hemoglobin Concentration** *(Hb / Hct) x 100 or (MCH / MCV) x 1'000 (g / L)*

RETICULOCYTE COUNT

Cf. next page

MORPHOLOGICAL CLASIFICATION OF ANEMIAS			
	MCV	MCH	MCHC
Normocytic normochromic	normal	normal	normal
Microcytic hypochromic	↘	↘	↘
Macrocytic normochromic	↗	↗	normal

RETICULOCYTES

Reticulocytes are RBC at the end of their maturation, already without nucleus. They are bigger and their cytoplasm contains RNA residues. They have left bone marrow and circulate in peripheral blood. Their number reflects medullar erythropoietic activity

Absolute reticulocyte count :

< 120 G / L : Hyporegenerative anemia

> 120 G / L : Regenerative anemia

Reticulocyte production index (RPI)

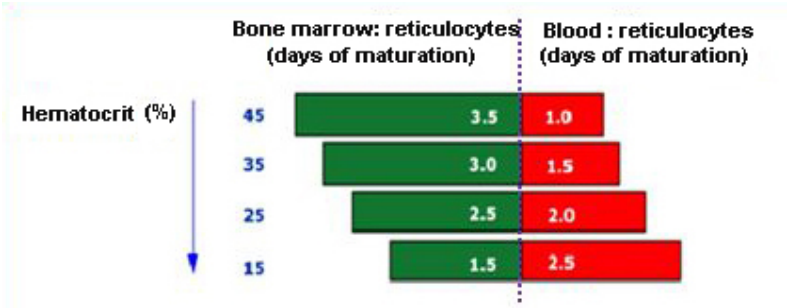
RPI = [‰ reticulocytes / 10 x maturation time** (days) **of reticulocytes** (blood)[1] **] x [Hematocrit / 45]

Normal : 1.0 - 2.0

Hyporegenerative anemia : < 2.0

Regenerative anemia : > 2.0

Reticulocyte maturation related to anemia severity[1]



[1] **Reticulocyte have a total maturation time of 4.5 days :**

- **Normally 3.5 days in bone marrow and 1 day in peripheral blood**
- **In case of hematocrit reduction reticulocytes leave the bone marrow earlier at a less mature stage → maturation > 1.0 day in peripheral blood** *(where the reticulocyte count is performed)*

Reticulocytes distribution related to RNA[2] content :

HFR (High-Fluorescence Reticulocytes) : high Immature reticulocytes *(IRF : Immature Reticulocyte Fraction[3])*

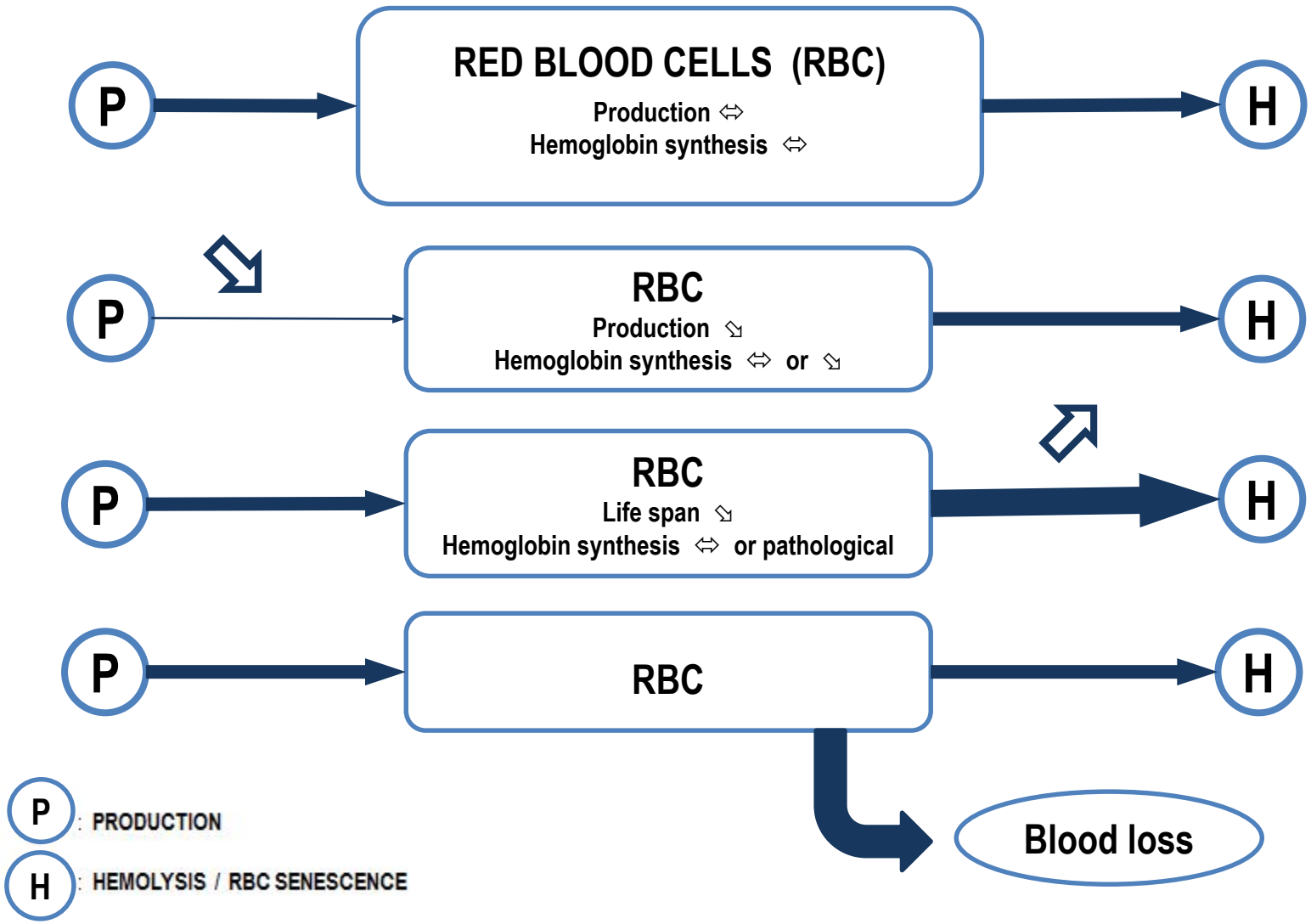
MFR (Medium-Fluorescence Reticulocytes) : medium

LFR (Low-Fluorescence Reticulocytes) : low Mature reticulocytes

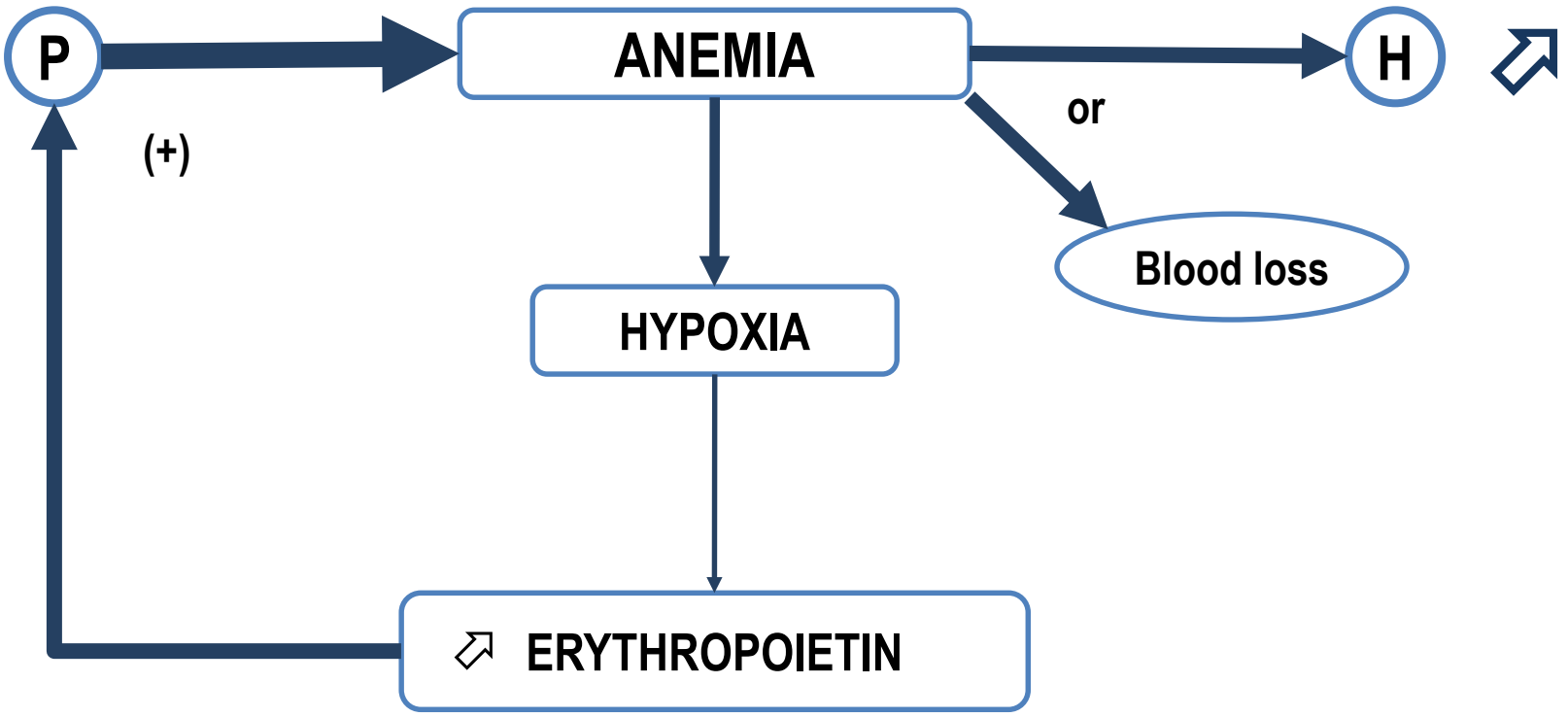
[2] **By flow cytometry**

[3] **Increase of this fraction may precede the reticulocyte increase in peripheral blood. Therefore it can be an early sign of recovery or stimulation of erythropoiesis. e.g. : a) after bone marrow / stem cell transplantation; b) monitoring of EPO treatment**

MECHANISMS OF ANEMIA



MECHANISMS OF ANEMIA (2)

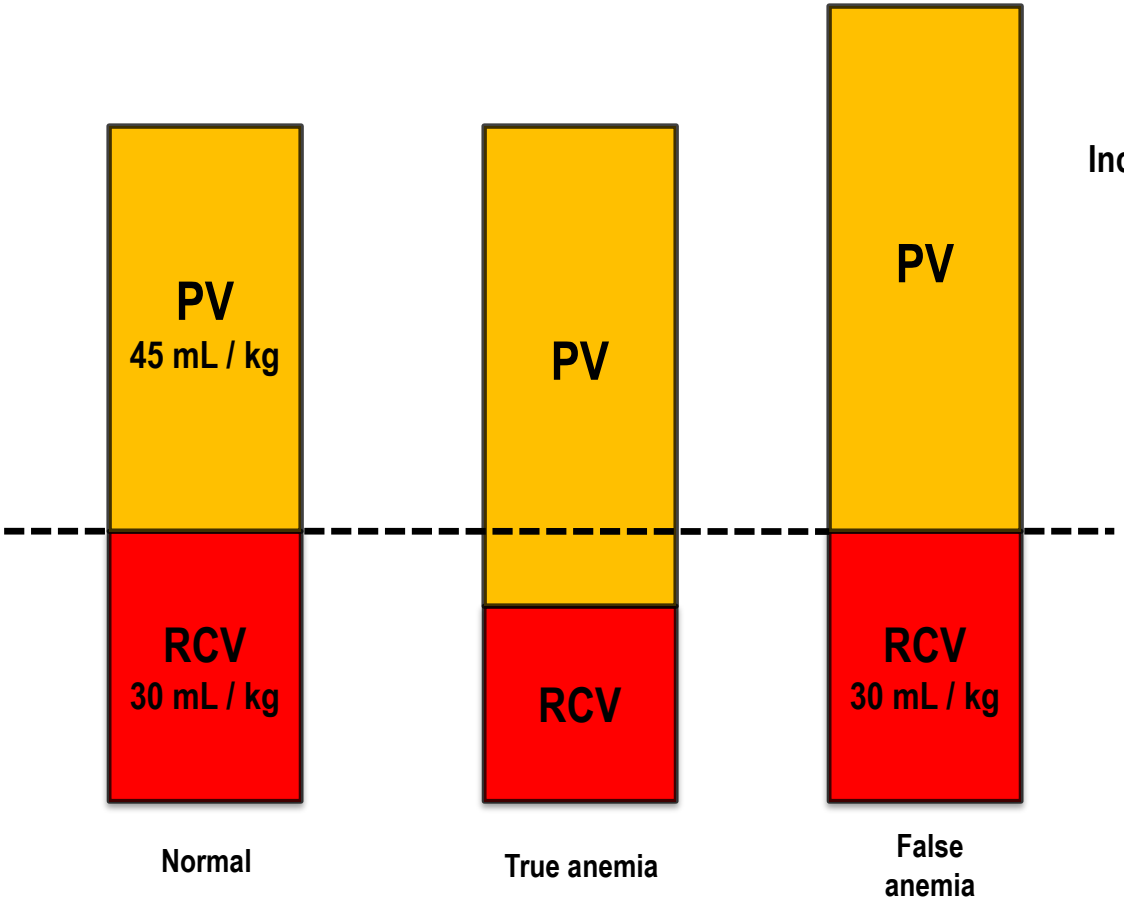


P : PRODUCTION

H : HEMOLYSIS / RBC SENESCENCE

MECHANISMS OF ANEMIA (3)

WHOLE BLOOD, RED CELL, PLASMA VOLUME



Increased plasma volume

Pregnancy
Paraprotein
Splenomegaly
Liver cirrhosis

RCV : Red Cell Volume

PV : Plasma Volume

ANEMIA
PATHOPHYSIOLOGICAL CLASSIFICATION

HYPOREGENERATIVE ANEMIA

Reticulocyte count < 120 G / L / RPI[1] < 2.0

NORMOCYTIC NORMOCHROMIC
- Renal failure
- Pure Red Cell Aplasia (Erythroblastopenia)
- Bone marrow aplasia
- Bone marrow infiltration
- Anemia of chronic disease / Inflammatory anemia
- Hypothyroidism

MICROCYTIC HYPOCHROMIC
- Iron deficiency
- Anemia of chronic disease / Inflammatory anemia
- Iron utilization disorder

MACROCYTIC NORMOCHROMIC
- Vitamin B_{12} and / or folate deficiency
- Cytotoxic drugs
- Alcoholism, liver disease, hypothyroidism
- Myelodysplastic syndrome
- Bone marrow aplasia

REGENERATIVE ANEMIA

Reticulocyte count > 120 G / L / RPI[1] > 2 / IRF[2] ⇗

NORMOCYTIC NORMOCHROMIC
- Acute blood loss
- Hemolytic anemia

[1] RPI : Reticulocyte Production Index
[2] IRF : Immature Reticulocyte Fraction

HYPOREGENERATIVE NORMOCYTIC NORMOCHROMIC ANEMIA

MCV :	**normal**	**81 – 99 fL**
MCH :	**normal**	**27 – 34 pg**
MCHC :	**normal**	**310 – 360 g / L**
Reticulocyte count :		**< 120 G / L**

CLASSIFICATION

SOLITARY ANEMIA

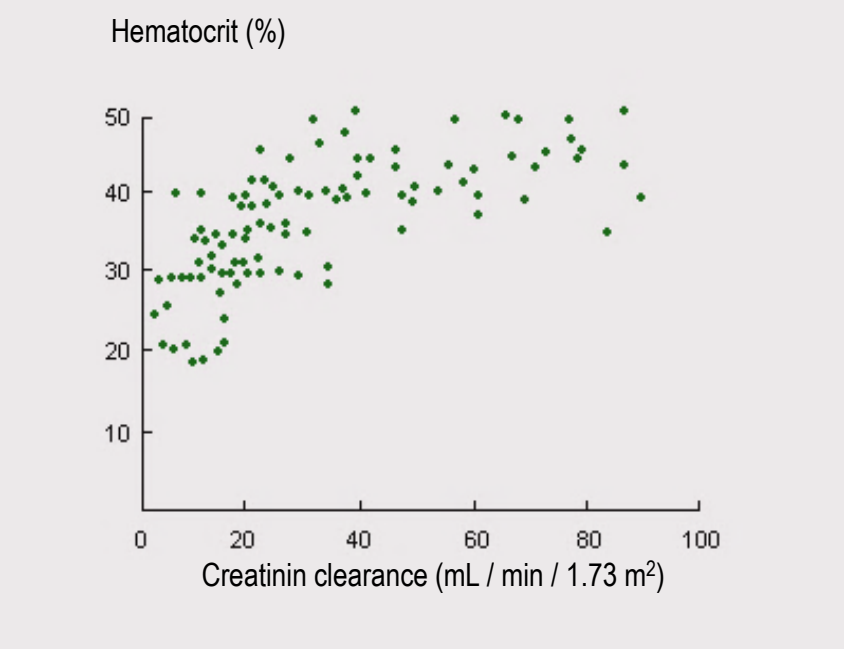
- **RENAL FAILURE**
- **PURE RED CELL APLASIA (ERYTHROBLASTOPENIA)**
- **HYPOTHYROIDISM**[1]

IN THE CONTEXT OF PANCYTOPENIA *("CENTRAL" ORIGIN)*

- **BONE MARROW APLASIA**[1]
- **BONE MARROW INFILTRATION** *(Acute leukemia, lymphoid neoplasm, metastatic cancer)*
- **BONE MARROW FIBROSIS**
- **HEMOPHAGOCYTOSIS**

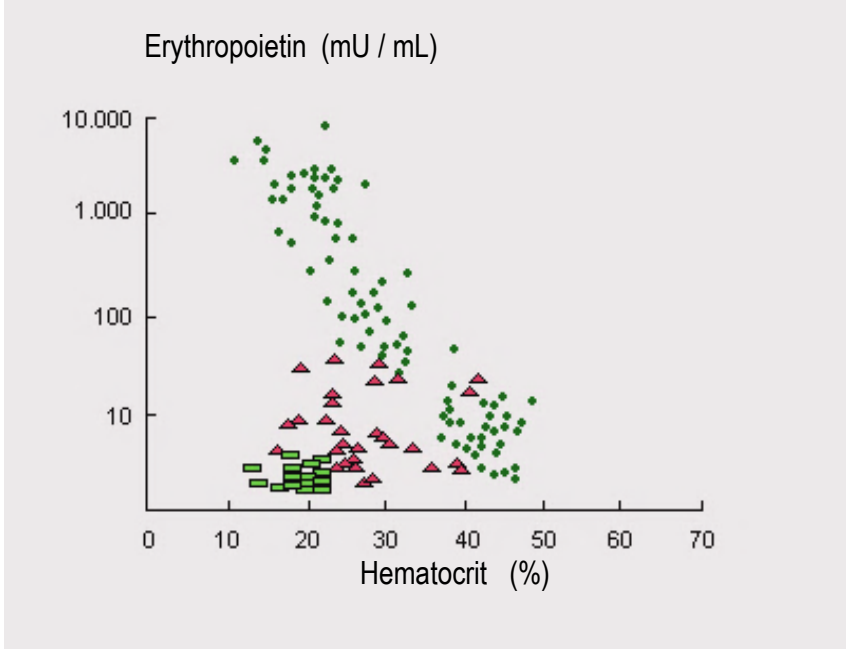
[1] **Normocytic or slightly macrocytic anemia**

ANEMIA OF RENAL FAILURE



Relation between hematocrit and creatinin clearance

Radtke H.W., 1979.



Relation between hematocrit and endogenous erythropoietin

Renal anemia : Absence of kidney

Presence of kidneys

Non renal anemia :

Modified from Caro J., 1979.

Treatment : rHuEpo 100-300 U / kg / week IV or SC

In Beutler E., Lichtman M.A., Coller B.S., Kipps T.J. : Williams Hematology, 5th edition 1995; McGraw-Hill : p. 456 & 458.

PURE RED CELL APLASIA - ERYTHROBLASTOPENIA

HEREDITARY

BLACKFAN-DIAMOND ANEMIA

ACQUIRED

PRIMARY

SECONDARY

THYMOMA *(~ 5% thymomas are associated with red cell aplasia)*
LYMPHOID NEOPLASM
CANCER *(lung, breast, stomach, thyroid, biliary tract, skin)*
COLLAGEN VASCULAR DISEASE
PARVOVIRUS B19
PREGNANCY
DRUG INDUCED :

- **Anticonvulsants**
- **Azathioprine**
- **Chloramphenicol**
- **Sulfonamides**
- **Isoniazid**
- **Procainamide**

BONE MARROW APLASIA
ETIOLOGY

HEREDITARY BONE MARROW APLASIA

FANCONI ANEMIA
DYSKERATOSIS CONGENITA

ACQUIRED BONE MARROW APLASIA

IDIOPATHIC APLASTIC ANEMIA (> 2/3 of cases)

SECONDARY APLASTIC ANEMIA

Irradiation
Chemicals *(benzene…)*
Drugs
Obligate bone marrow aplasia *(direct cytotoxicity)*
Cytotoxic drugs *(alkylating agents)*
Occasional or uncommon bone marrow aplasia *(idiosyncratic reaction, probably immune mediated)*
Chloramphenicol
Phenylbutazone
Gold salts
Viral infection *(EBV, Hepatitis, Parvovirus B19, CMV, HIV)*
Immune disorder *(thymoma)*
Paroxysmal Nocturnal Hemoglobinuria *(PNH)*
Hypoplastic myelodysplastic syndrome
Pregnancy

APLASTIC ANEMA DUE TO CHLORAMPHENICOL		
	DOSE RELATED TOXICITY	DOSE UNRELATED TOXICITY
INCIDENCE	Frequent	Rare
ONSET	Immediate	Delayed (some months)
SYMPTOMS	Light	Severe (infection, bleeding)
COURSE	Spontaneously favorable	Frequently fatal

APLASTIC ANEMIA (AA)
GENERAL DATA

Stem cell failure leading to pancytopenia without splenomegaly

Immune mechanisms play an etiologic role in idiopathic AA

FEATURES :

- **Severe bone marrow hypocellularity with decrease in all cell lines and remaining fat and marrow stroma**
- **Normal residual hematopoietic cells. Absence of fibrosis or infiltration by abnormal** *(malignant)* **cells**
- **Non megaloblastic hematopoiesis** *(light RBC macrocytosis in peripheral blood is frequent)*
- **Symptoms of pancytopenia : bleeding, relapsing infections depending upon severity of the disease**

CLASSIFICATION :

MODERATE AA	SEVERE AA (SAA)	VERY SEVERE AA (VSAA)
Marrow cellularity < 30% of normal ↘ of at least 2 of 3 cell lines below normal. ANC[2] > 0.5 G / L	Marrow cellularity < 20% of normal and at least 2 of following criteria : ARC[1] < 40 G / L / ANC[2] < 0.5 G / L / platelets < 20 G / L	Similar to SAA but with : ANC[2] < 0.2 G / L and / or infection(s)

[1] ARC : Absolute Reticulocyte Count

[2] ANC : Absolute Neutrophil Count

PROGNOSIS :

- **Related to severity of the disease**
- **Without treatment less than 30% of patients with SAA or VSAA survive at 1 year**
- **Response to treatment depends on the type of therapy, on patient age which limits indication to bone marrow transplantation**
- **No age related limitation for immunosuppressive therapy**

APLASTIC ANEMIA (AA) (2)
TREATMENT

TREATMENT :

Withdrawal of potentially offending agents

Supportive care *(Blood and platelet transfusions to be used selectively in candidates to HST[1])*

Immunosuppressive treatment (IST) :

Anti-thymocyte globulin + Cyclosporin (± high dose steroids), mostly used

Hematopoietic stem cell transplantation (HST) :

Syngeneic, allogeneic in case of HLA-matched sibling / HLA-matched unrelated donor, reduced intensity conditioning transplant

MODERATE AA	SEVERE AA & VERY SEVERE AA		
ALL AGES	**< AGE 20**	**AGE 20 - 40**	**> AGE 40[2]**
Imunosuppression : *Anti-thymocyte globulin (ATG)* *+ Cyclosporin* *± steroids ± G-CSF*	**HST if HLA-matched sibling donor** **If not, immunosuppression :** *Anti-thymocyte globulin (ATG)* *+ Cyclosporin* *± steroids ± G-CSF* **Consider HST[1] from HLA-matched unrelated donor for a child or adolescent patient with VSAA**	**HST if HLA-matched sibling donor** **If not, immunosuppression :** *Anti-thymocyte globulin (ATG)* *+ Cyclosporin* *± steroids ± G-CSF* **Possibly HST from HLA-matched unrelated donor**	**Imunosuppression :** *Anti-thymocyte globulin (ATG)[3]* *+ Cyclosporin* *± steroids ± G-CSF*

[1] HST : Hematopoietic Stem cell Transplantation
For SAA and VSAA bone marrow transplantation appears superior to transplantation with peripheral blood hematopoietic stem cells

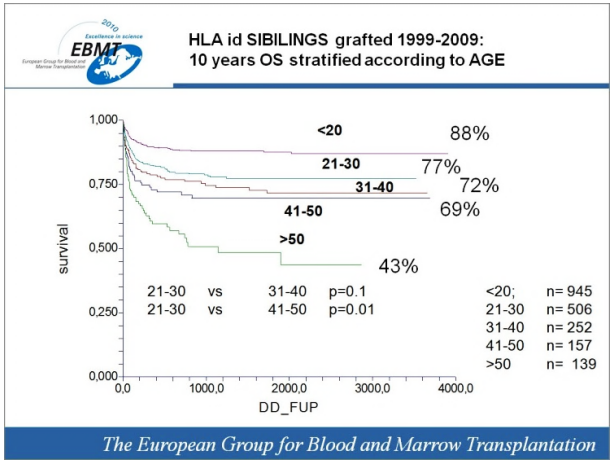
[2] Risk of transplant related mortality (e.g. GVHD) increasing with age

[3] For elderly patient with SAA or VSAA immunosuppressive treatment should omit ATG because of its toxicity

APLASTIC ANEMIA (AA) (3)
TREATMENT (2)

BONE MARROW TRANSPLANTATION vs IMMUNOSUPRESSIVE TREATMENT

❶



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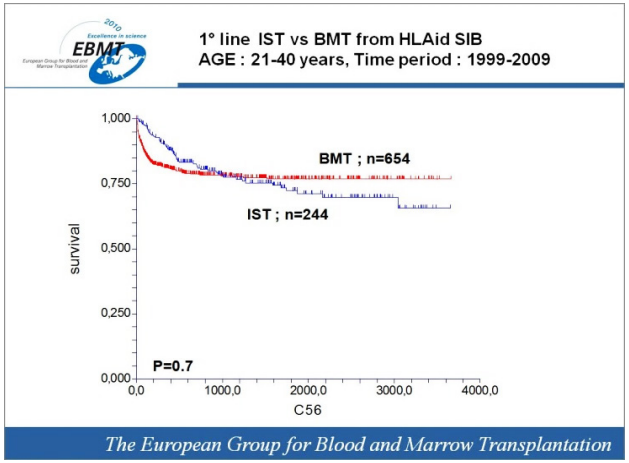

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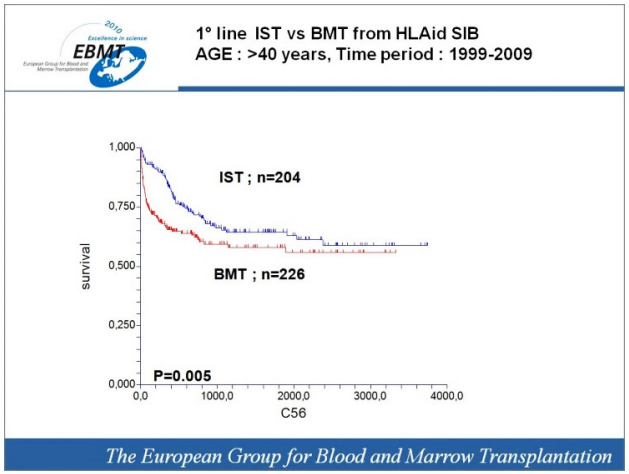


❶ **Survival of SAA patients treated by bone marrow transplantation (BMT)[1] is strongly age dependent. Increase of treatment related mortality proportional to age is the main cause**

❷ **For patients aged 21 to 40 years, bone marrow transplantation (BMT) appears equivalent to immunosuppressive treatment (IST), or slightly better at longer term**

❸ **Over 40 years of age, upfront IST is the treatment of choice**

[1] In SAA and VSAA transplantation of bone marrow appears better than transplantation of peripheral blood stem cells

Probability to find an HLA-compatible sibling as bone marrow / hematopoietic stem cells donor : 20 - 30 %

MICROCYTIC HYPOCHROMIC ANEMIA
DECREASED MCV, MCH AND MCHC

IRON DEFICIENCY

Chronic blood loss
Increased demand
Malabsorption
Poor diet

ANEMIA OF CHRONIC DISEASE

Acute and chronic infection
Inflammatory disorder
Cancer
Rheumatoid arthritis

IRON UTILIZATION DISORDERS

HEMOGLOBIN DISORDER

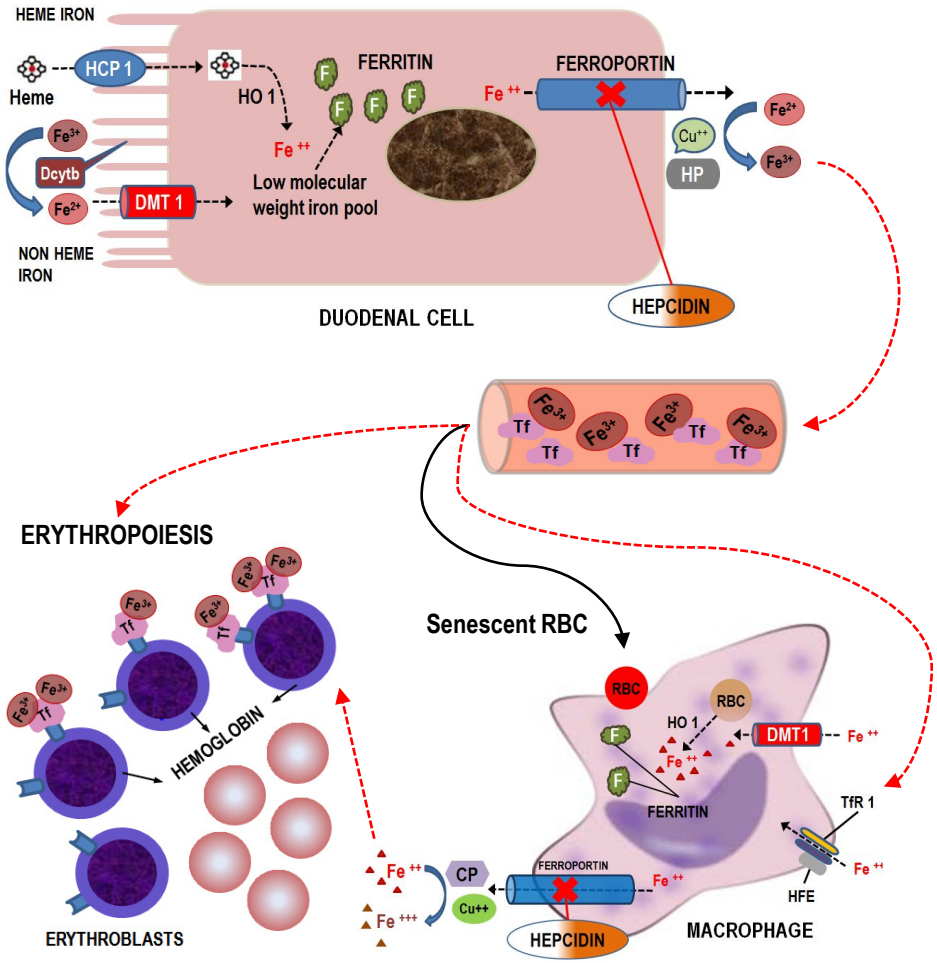
Thalassemias

SIDEROBLASTIC ANEMIA

Hereditary
Acquired : Primary
Secondary
Lead poisoning
Drugs
Alcohol

In case of iron deficiency or inflammatory disorder anemia is hyporegenerative.
In iron utilization disorders a hemolytic component can be observed with signs of regeneration, i.e. :
Thalassemias *(by instability of α or β tetramers)*
Lead poisoning *(by pyrimidine-5'-nucleotidase inhibition)*

IRON METABOLISM



[1] HCP 1 : Heme Carrier Protein 1
[2] Dcytb : Duodenal cytochrome b reductase
[3] DMT 1 : Divalent Metal Transporter 1
[4] TfR : Transferrin Receptor
[5] Hp : Hephaestin
[6] HO 1 : Heme Oxygenase 1
[7] CP : Ceruloplasmin
HFE : High Fe (Human hemochromatosis protein)

IRON ABSORPTION :

Heme iron :

1. Duodenal cell :
   Probably through **HCP 1**[1] pathway → heme degradation through **Heme Oxygenase (HO 1**[6]**)** → iron recycling → Low molecular weight Fe^{++} pool → binding to Ferritin *(binding up to 4'000 Fe^{++} atoms)*
2. Macrophage : phagocytosis of senescent RBC → heme degradation through **Heme Oxygenase 1 (HO 1**[6]**)** → Fe^{++} → Fe^{++} pool → Ferritin → Hemosiderin

Non-heme iron *duodenal cell / macrophage* :
reduction of Fe^{+++} to Fe^{++} by **Dcytb**[2] → absorption by **DMT 1**[3]

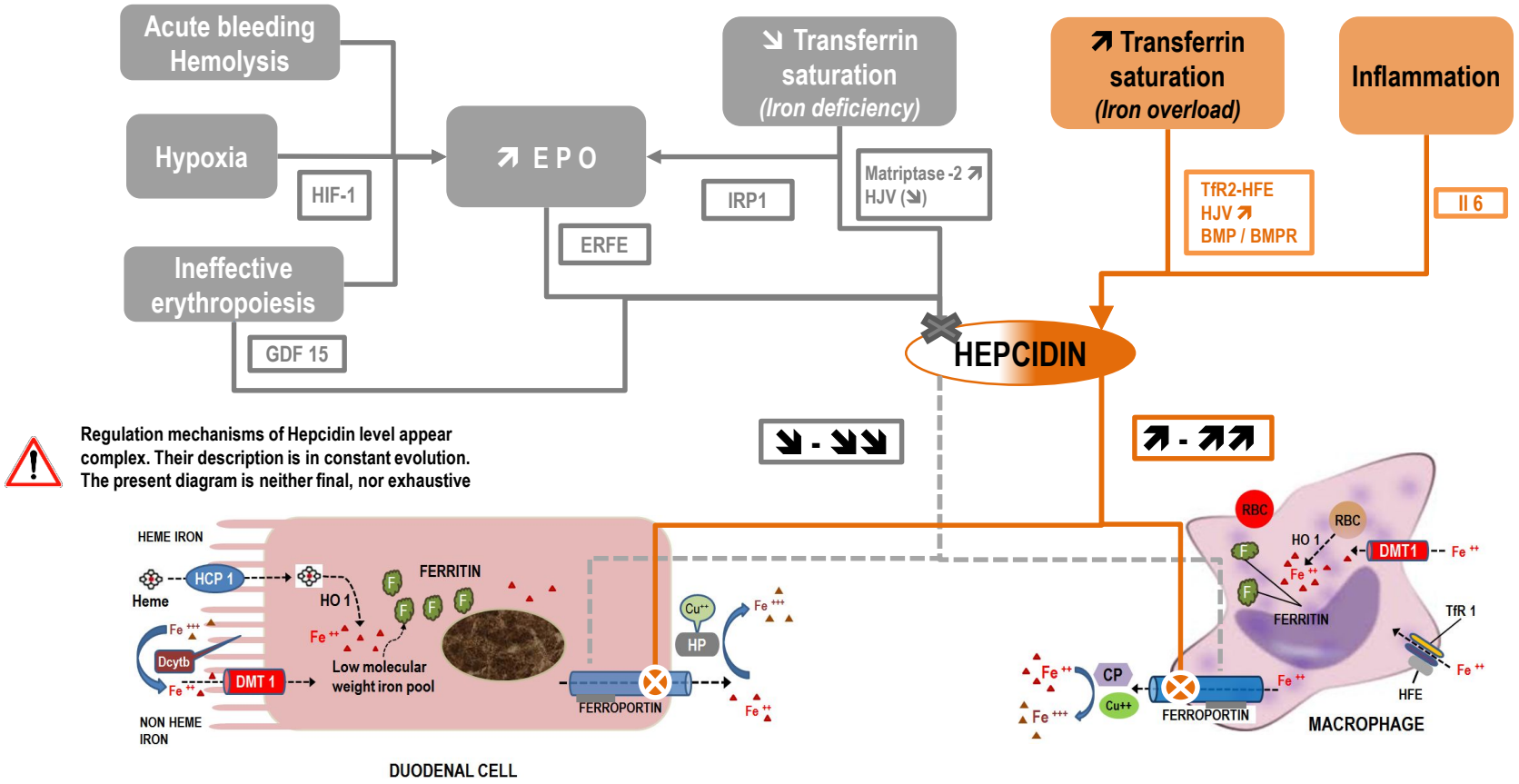
IRON CIRCULATION :

Fe^{++} leaves the cell *(duodenal cell or macrophage)* through the **Ferroportin** pathway, regulated by **Hepcidin** *(cf. below)* → Iron reoxidation to Fe^{+++} through **Hephaestin (Hp**[5]**)** *(duodenal cell)* or **Ceruloplasmin (CP**[7]**)** in presence of **Cu^{++}** *(macrophage)* → iron binding to **Transferrin (Tf)** *(specific bivalent transporter protein)* → iron dependent cells *(i.e. bone marrow erythroblasts for heme synthesis)* through binding to the **Transferrin Receptors (TfR**[4]**)**

⇗ **Hepcidin :** ⇘ **Ferroportin** *(cellular internalization)* → ⇘ iron release which remains in the cell → functional iron deficiency → iron overload in macrophages *(e.g. anemia of chronic disorders / inflammatory anemia)*

⇘ **Hepcidin :** ⇔ **or** ⇗ **Ferroportin** → favoring iron transfer to cells *(e.g. iron deficiency anemia)* cf. following page

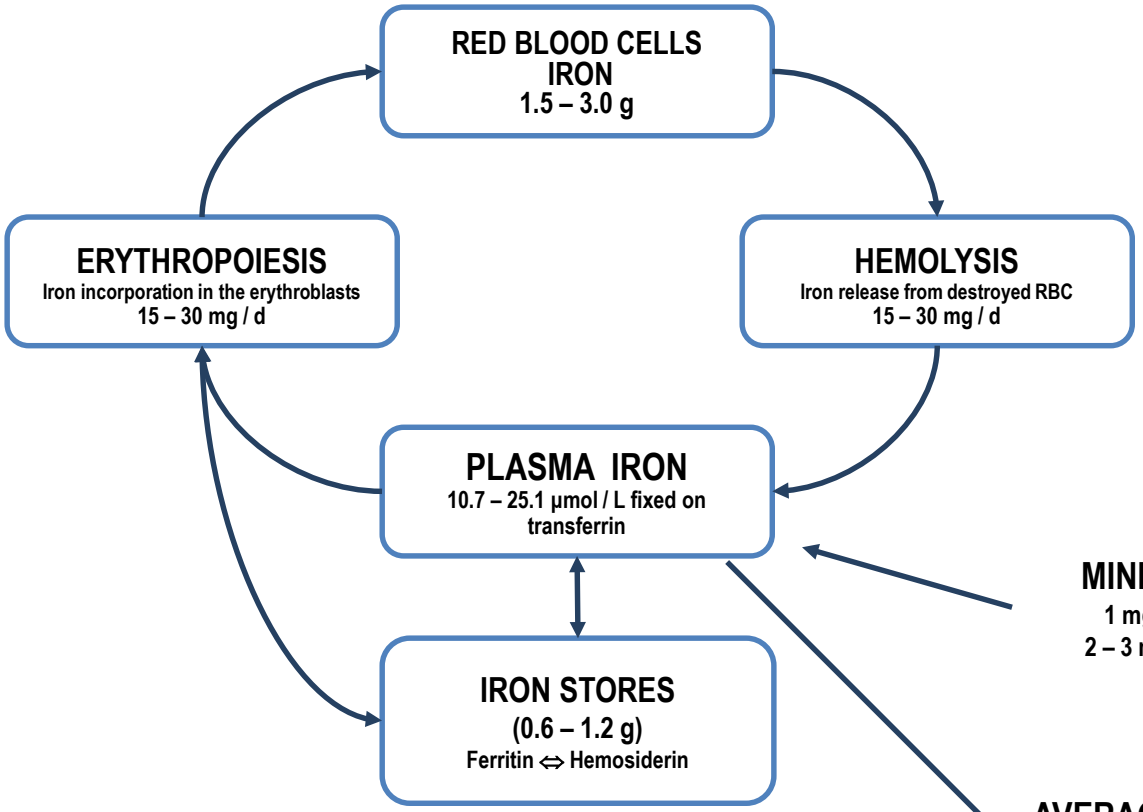
IRON METABOLISM
REGULATION BY HEPCIDIN



Rare mutations of **DMT1** or **Matriptase-2** genes cause iron deficiency anemia, refractory to oral iron administration
(**IRIDA** : Iron-Refractory Iron Deficiency Anemia)

BMP / BMPR : *Bone Morphogenetic Protein* / **CP** : *Caeruloplasmin* / **DMT 1** : *Divalent Metal Transporter 1)* / **Dcytb** : *Duodenal Cytochrome B (Ferrireductase)* / **ERFE :** *Erythroferrone produced by erythroblasts is a strong inhibitor of Hepcidin (stress erythropoïesis)* / **GDF 15 :** *Growth Differentiation Factor 15* / **HCP 1** : *Heme Carrier Protein 1* / **HFE** : *High Fe (Hemochromatosis protein)* / **HIF-1** : *Hypoxia Induced Factor 1* / **HJV** : *Hemojuvelin* / **HO 1** : *Heme Oxygenase 1* / **HP** : *Hephaestin* / **IRP1** : Iron Regulatory Protein 1 / **Matriptase-2** : *membrane protein (Gene : TMPRSS6) ⇨ Hemojuvelin lysis* / **TfR** : *Transferrin Receptor*

IRON CYCLE



MINIMAL INTAKE
1 mg / day (Male)
2 – 3 mg / day (Female)

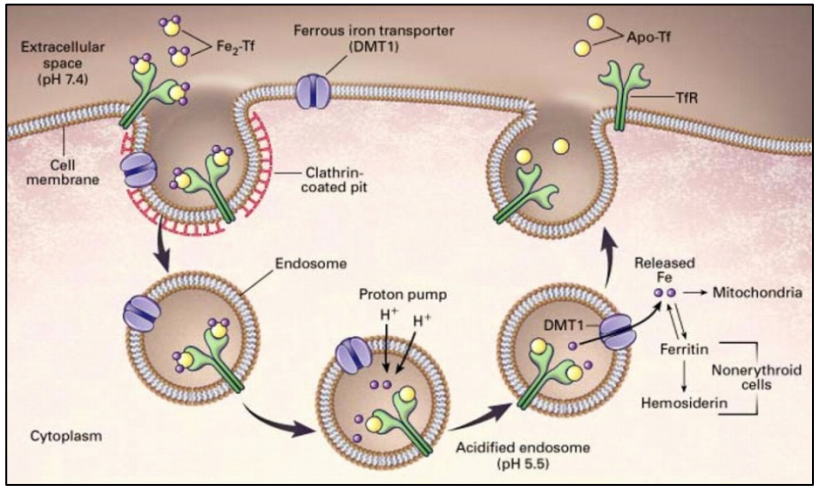
AVERAGE NORMAL LOSSES
1 mg / day (Male)
2 – 3 mg / day (Female)

Normal range[1] :			
Iron (serum)	12.5 – 25.1 µmol / L (M[2])	10.7 – 21.4 µmol / L (F[3])
Transferrin	24.7 – 44.4 µmol / L	
TSC	0.20 – 0.40 (H[2])	0.15 – 0.35 (F[3])
Ferritin (serum)	6 months - 2 years	15 – 120 µg / L
	M : > 2 years	30 – 300 µg / L
	F : 2 - 50 years	10 – 160 µg / L
	F : > 50 years	30 – 300 µg / L

Transferrin saturation coefficient (TSC)
Iron (µmol / L) / 2 x Transferrin (µmol / L)

[1] *LCC-CHUV, 2015*
[2] *M : Male*
[3] *F : Female*

TRANSFERRIN CYCLE



TfR : Transferrin Receptor. Binds 2 molecules of bivalent transferrin
DMT 1 : Divalent Metal Transporter 1. Transport in the cell of non-heme iron
APO-Tf : Apotransferrin

Andrews N.C. : Disorders of Iron Metabolism. NEJM 1999; 341 : 1986-1995.

REGULATION OF FERRITIN, TRANSFERRIN RECEPTOR AND DMT 1

IRP : Iron Regulatory Protein(s) *(sensors of intracellular labile iron)*
IRE(s) : Iron Responsive Elements *(mRNA motives)*

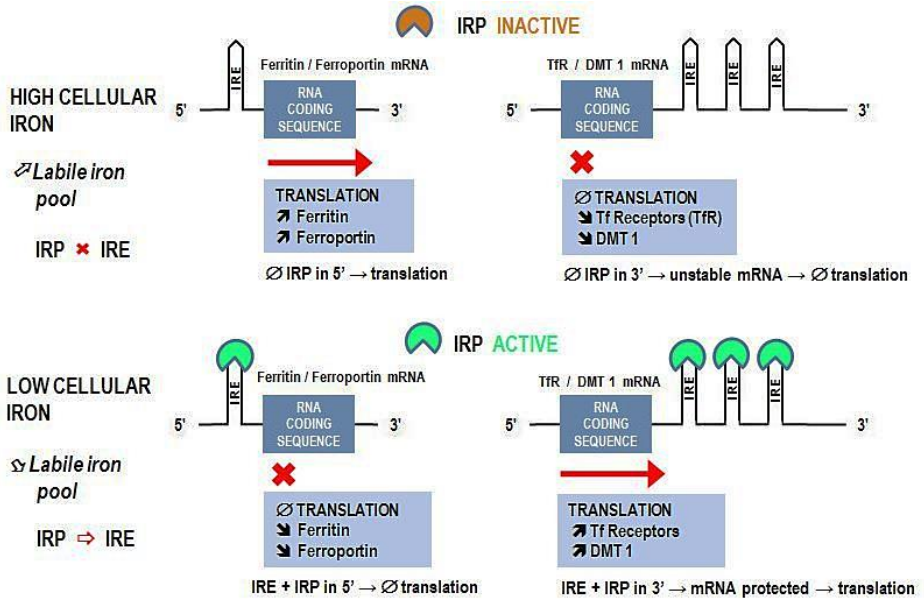
Interactions between IRE(s) and IRP lead to regulation of ferritin, DMT 1 and transferrin receptor (TfR) synthesis related to the iron load of the labile intracellular pool

High cellular iron *(iron overload)* → **IRP(s) with low or absent activity :**

1. ⬀ Ferritin and ferroportin mRNA → ⬀ synthesis → ⬀ iron storage facility
2. ⬂ TfR and DMT 1 mRNA → ⬂ synthesis → ⬂ iron absorption and transport capacity

Low intracellular iron pool *(iron deficiency)* → **IRP(s) active → IRE binding :**

1. ⬂ Ferritin and ferroportin mRNA → ⬂ synthesis → ⬀ iron circulation
2. ⬀ mRNA of TfR and DMT 1 → ⬀ synthesis → ⬀ absorption and transport of iron



IRON DEFICIENCY ANEMIA
PHYSIOLOGICAL IRON LOSSES

MAN : **1 mg / day : basal losses** *(cellular desquamation of integuments, urinary and digestive tracts, sweat)*

WOMAN : **1 mg / day : basal losses**

+ menstruations : **2 – 3 mg / day** **– 50% if oral contraception**
+ 100% if intrauterine device

IRON BIOAVAILABILITY

ABSORPTION :

Heme iron **25 – 30%**
Non heme iron **1 – 7%**

- ⇗ **Ascorbates, citrates, tartrates, lactates**
- ⇘ **Tannates, wheat, calcium, phosphates, oxalates, soya proteins**

STAGES OF IRON DEFICIENCY DEVELOPMENT

	STAGE 1	STAGE 2	STAGE 3
FERRITIN	↘	↘	↘
IRON (Bone marrow)	↘	Absent	Absent
TRANSFERRIN (Serum)	Normal	↗	↗
IRON (Serum)	Normal	↘	↘
HEMOGLOBIN	Normal	Normal	↘
MCV	Normal	Normal	↘
MCHC	Normal	Normal	↘

MICROCYTIC HYPOCHROMIC ANEMIA

SERUM IRON - TRANSFERRIN - FERRITIN

	SERUM IRON	TRANSFERRIN	FERRITIN
IRON DEFICIENCY	↘	↗	↘
INFLAMMATORY ANEMIA	↘	↘	↗
IRON UTILIZATION DISORDER	↗	no / ↘	↗

SOLUBLE TRANSFERRIN RECEPTORS :

Increased in isolated iron deficiency but also when combined with inflammatory processes
Normal in isolated inflammatory anemia

RBC ZINC PROTOPORPHYRIN (low specificity) :

Increased in severe iron deficiency, but also in inflammatory anemia and lead poisoning

RING SIDEROBLASTS :

Increased in sideroblastic anemia *(indication to bone marrow examination)* *(cf. p.36)*

ETIOLOGY OF IRON DEFICIENCY

Chronic blood loss
Increased iron demand
Malabsorption
Poor diet

CAUSES OF CHRONIC IRON LOSS

Uterine *(menorrhagia, metrorrhagia)*, **digestive bleeding** *(hematemesis, melaena, occult bleeding)*, **parasites** *(hookworm)*, **hematuria**
Chronic intravascular hemolysis *(Paroxysmal Nocturnal Hemoglobinuria)*
Frequent blood donations, phlebotomies, provoked bleedings *(Lasthénie de Ferjol syndrome)*

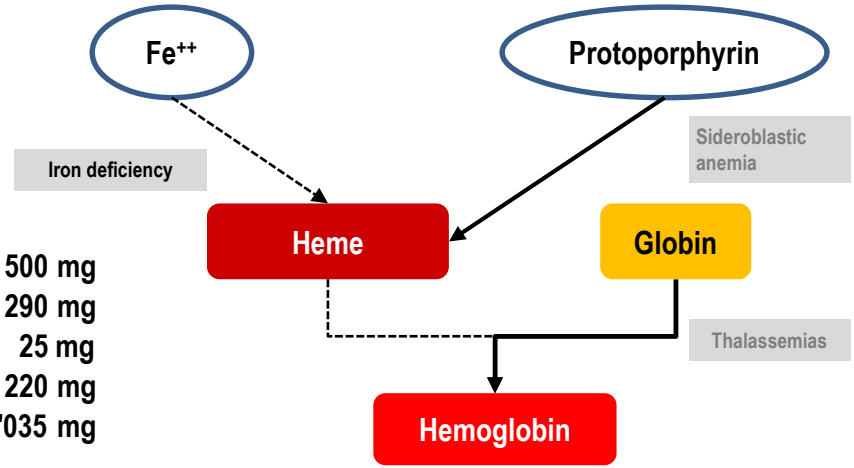
Chronic bleeding (microcytic hypochromic hyporegenerative anemia) must imperatively be distinguished from acute blood loss (normocytic normochromic regenerative anemia). Remember that 1 L of blood = 500 mg of iron

INCREASED IRON DEMAND

Pregnancy
Breast feeding *(maternal milk : 0.3 – 0.5 mg / L)*
Growth

IRON DEMAND IN PREGNANCY

Increased maternal total red cell volume	**500 mg**
Fetal needs	**290 mg**
Placenta	**25 mg**
Basal iron loss *(0.8 mg / d for 9 months)*	**220 mg**
TOTAL :	**1'035 mg**



FUNCTIONAL IRON DEFICIENCY

Absence of adequate erythropoietin response in case of anemia secondary to renal failure or to an inflammatory process with ferritin level in normal or high range *(cf. p. 34-35)*

TREATMENT OF IRON DEFICIENCY ANEMIA

CAUSAL TREATMENT

IRON SUBSTITUTION (anemia correction and iron stores reconstitution)

Oral substitution :

Basic data : *1 L of blood = 500 mg of iron and 160 g of hemoglobin.1 g of hemoglobin : 500 / 160 = ± 3 mg of iron*
Blood volume : 75 mL / kg. Iron reserves : 1'000 mg

Example : ***Woman, 56 years old, BW 50 kg, hemoglobin 80 g / L***
Iron needs for anemia correction and iron stores reconstitution

[Blood volume (L) x (160 - Hb patient) x 3] + 1'000 mg → [3.75 x (160 – 80) x 3] + 1'000 mg = 1'900 mg of iron

Patient receives 100 mg elementary iron q.d. with a mean resorption of 15 mg q.d.
Duration of substitution : 1'900 / 15 = 126 days (± 4 months)
Anemia correction within ± 1 month. Iron deficiency corrected when serum ferritin in normal range

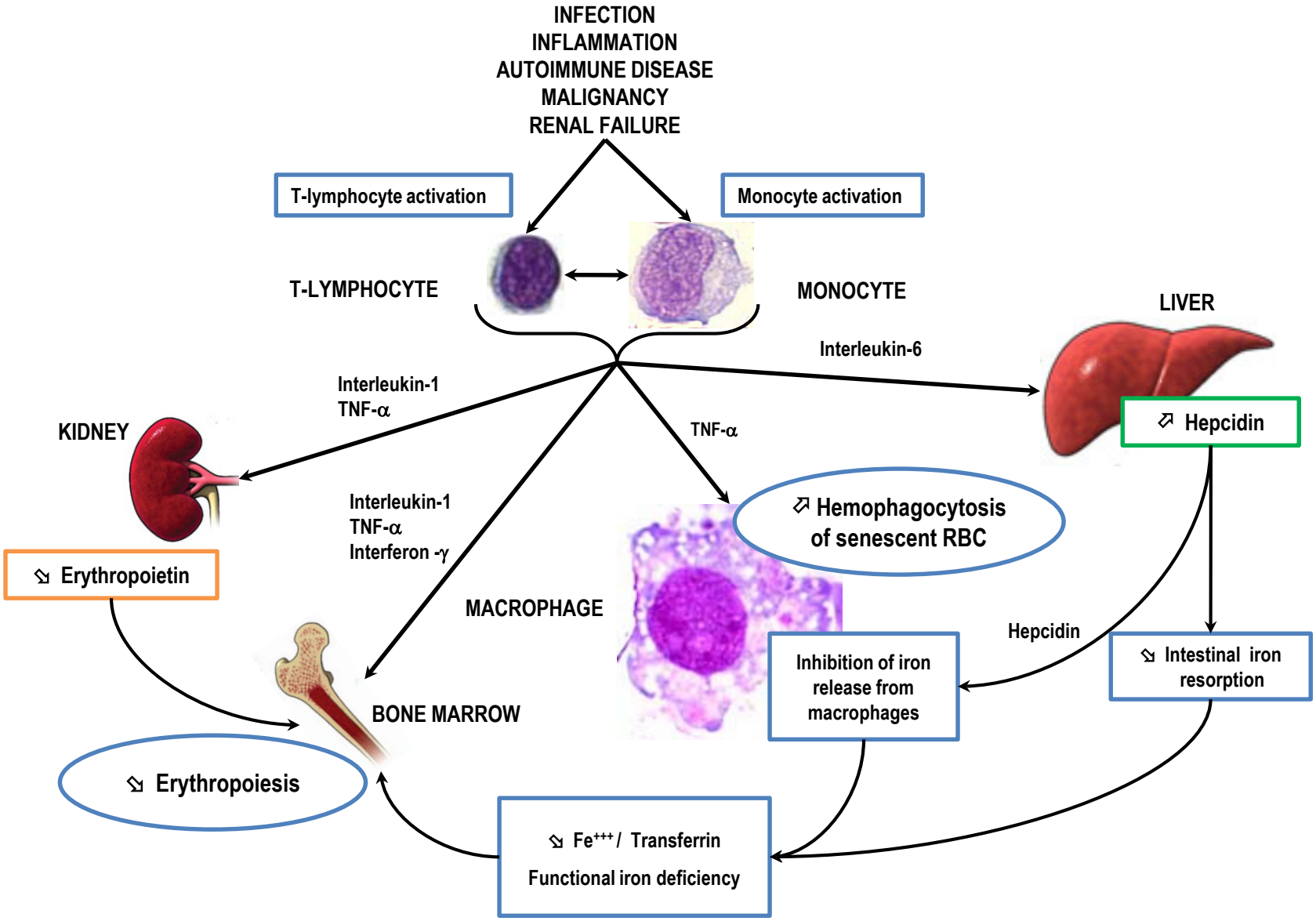
Parenteral substitution : *1-3 perfusion(s) of 500 mg (15 mg / kg) of ferric carboxymaltose or 100-200 mg iron oxyde saccharose 1-3 x weekly IV*

Indications : *Functional iron deficiency (Hb content in reticulocytes (CHr[1]) < 28 pg; hypochromic RBC fraction (HYPO[1] : > 5%)*
Malabsorption syndrome
Digestive oral iron intolerance
Poor patient compliance
Important chronic, persisting hemorrhage
Rare mutations of DMT 1 genes (vegetarians[2]) or of Matriptase-2 : IRIDA *(cf. p. 28)*

[1] These 2 parameters can only be measured by certain hematological analyzers

[2] In case of normal balanced diet, DMT 1 mutations have no consequence, due to normal absorption of heme iron through HCP 1 pathway

ANEMIA OF CHRONIC DISORDERS / INFLAMMATORY ANEMIA



ANEMIA WITH IRON UTILIZATION DISORDER
SIDEROBLASTIC ANEMIA

GENERAL DATA

Anomaly of porphyric nucleus synthesis

↘ iron utilization with frequent iron overload (hemosiderosis)

Peripheral blood : Microcytic anemia, normochromic or macrocytic
Erythrocytic polymorphism (size and chromia)
Coarse basophilic stippling. Siderocytes (Perl's staining[1])

Bone marrow : Ring sideroblasts *(iron granules arranged around cell nucleus)*

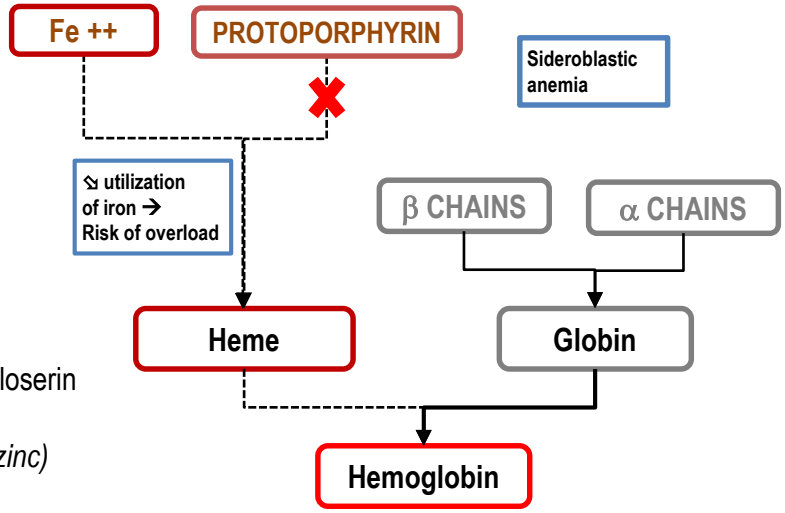
CLASSIFICATION

Hereditary disorders : *X-linked, autosomal or mitochondrial*
Mostly : mutations of *ALA-S*[2] gene *(X chromosome)*

Acquired disorders :

Primary : Clonal (neoplastic)
Refractory sideroblastic anemia, *cf. MDS, p. 140*

Secondary Non clonal (metabolic / reversible)
Lead intoxication *(cf. p. 85)*
Isoniazide, Chrloramphenicol, Pyrazinamide, Cycloserin
Alcool
Copper deficiency *(secondary to excess dietary zinc)*



TREATMENT

In secondary non clonal forms : suppression of cause

Pyridoxine (vitamin B_6) : 2/3 of favorable response in *ALA-S* gene mutations

Chelation in case of iron overload in chronic forms *(serum ferritin > 500 µg / L)*

[1] Perls staining : Prussian blue staining

[2] ALA-S : δ-aminolevulinic acid synthetase

IRON OVERLOAD / HEMOSIDEROSIS

PRIMARY HEMOSIDEROSIS or HEMOCHROMATOSIS

Increased absorption of dietary iron → hypeferritinemia, ⇗ % of transferrin saturation

***HFE* mutations :**	**C282Y homozygocity** **C282Y / H63D double heterozygocity, other *HFE* mutations**
Non *HFE* mutations :	**Juvenile hemochromatosis** *(Hemojuvelin or Hepcidin mutations)* **Other mutations** *(ferroportin, transferrin receptor 2)*
Clinical manifestations :	**Hepatic involvement** (fibrosis, cirrhosis, possibly hepatocarcinoma)**, cutaneous, endocrine** ("bronze diabetes"), **cardiac**, **articular, unexplained fatigue, sleepiness**
Treatment :	**Phlebotomies** (goal : reach and maintain serum ferritin within normal values)

SECONDARY HEMOSIDEROSIS

Anemias with iron utilization disorders ± iron overload

- **Thalassemia major or intermediate** *(cf. p. 79)*
- **Sideroblastic anemia** *(cf. previous page)*
- **Myelodysplastic syndrome** *(cf. p. 137-146)*

Anemias with risk of transfusion induced iron overload

- **Chronic hemolytic anemia** *(i.e. sickle cell anemia, cf. p. 80)*
- **Aplastic anemia** *(cf. p. 23-25)*

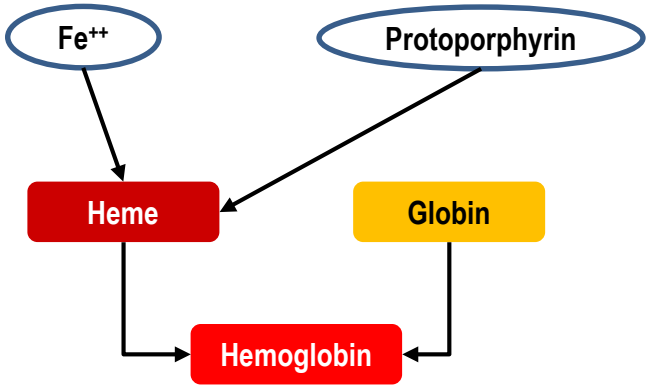
Dietary iron overload

Chronic hepatopathy

MISCELLANEOUS CAUSES

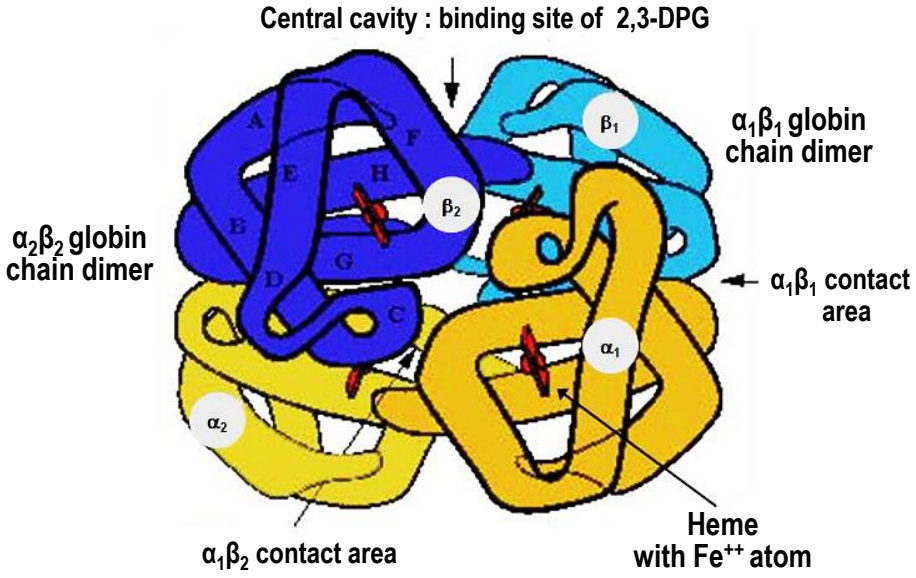
African type iron overload
Neonatal iron overload
Aceruloplasminemia

STRUCTURE OF HEMOGLOBIN / INTERACTION O_2 AND 2,3-DPG

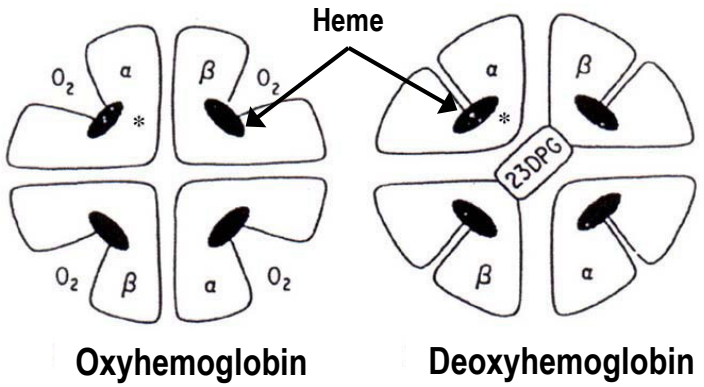


Hemoglobin is built of 4 globin chains and 4 heme groups contaning 1 Fe^{++} atom each, able to bind O_2 in rich environment (capillaries of pulmonary alveoles) and to release it to the tissues, under influence of 2,3-diphosphoglycerate (2,3-DPG) which diminishes the oxygen affinity of hemoglobin

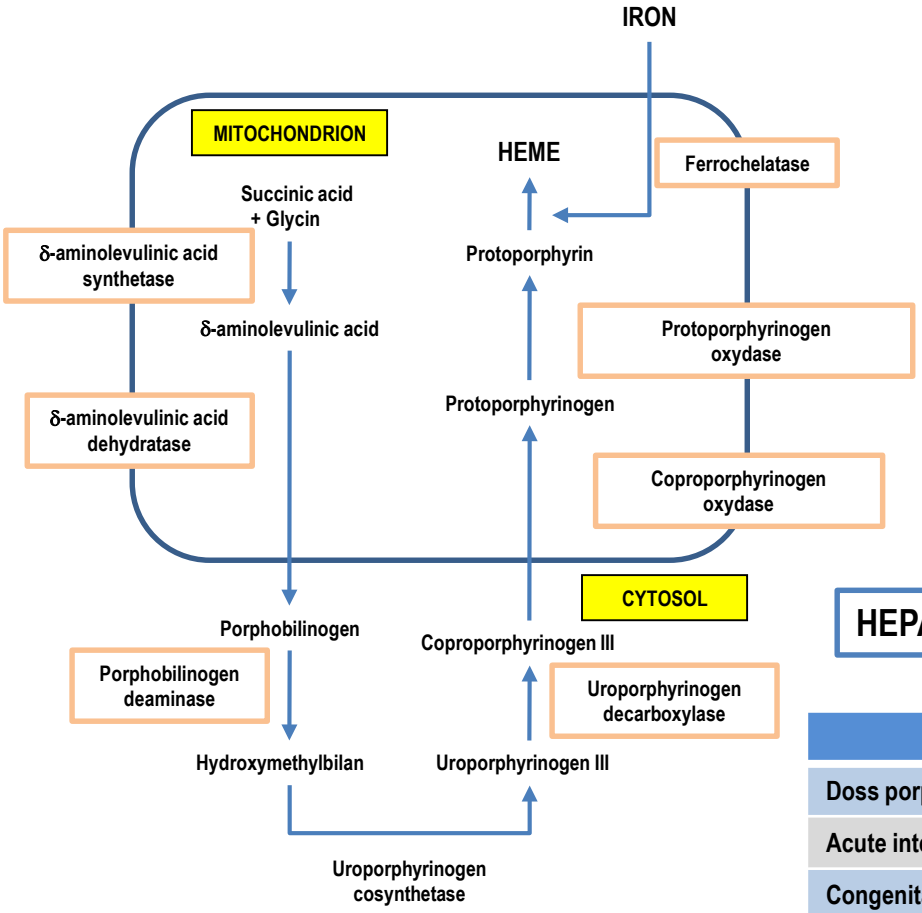
Hemoglobin tetramer



Competition between oxygen and 2,3-diphosphoglycerate (2,3-DPG)

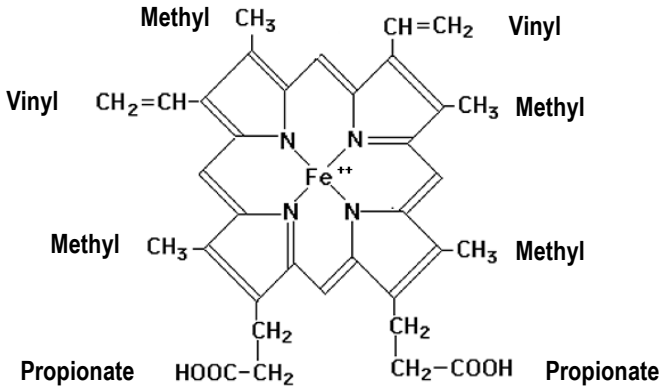


HEME SYNTHESIS



Wajcman H., Lantz B., Girot R. : Les maladies du globule rouge 1992; Médecine-Sciences. Flammarion : p. 418 & 420.

Porphyric nucleus + iron



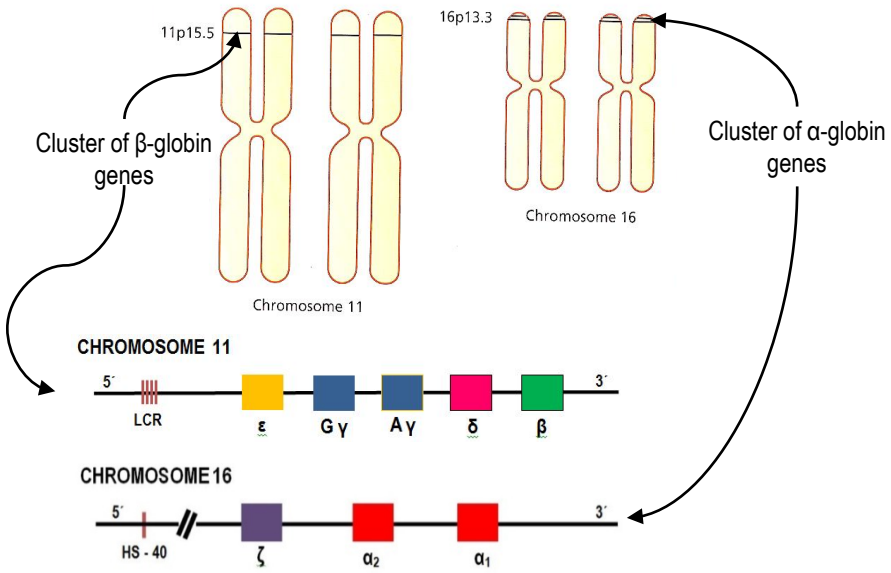
The heme molecule

HEPATIC (H) AND ERYTHROPOIETIC (E) PORPHYRIAS

DISEASE	TYPE	ENZYME DEFICIENCY
Doss porphyria	H	ALA dehydratase
Acute intermittent porphyria	H	Porphobilinogen deaminase
Congenital erythropoietic porphyria	E	Uroporphyrinogen cosynthetase
Cutaneous porphyria	H	Uroporphyrinogen decarboxylase
Hereditary coproporphyria	H	Coproporphyrinogen oxydase
Porphyria variegata	H	Protoporphyrinogen oxydase
Protoporphyria	E	Ferrochelatase

GLOBIN SYNTHESIS

GENES CODING FOR THE VARIOUS CHAINS OF GLOBIN

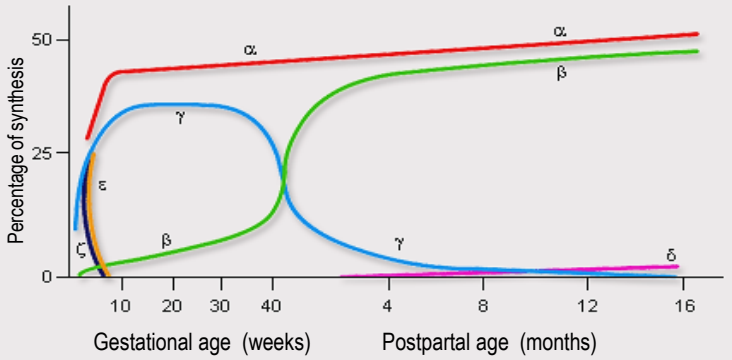


The genes coding for the various chains of globin are grouped in clusters on chromosomes 11 and 16

<u>On chromosome 11</u> : genes of globin chains β, δ, and γ of adult hemoglobins. The 2 different γ genes code for chains which differ for only 1 aminoacid, without functional consequence

<u>On chromosome 16</u> : 2 identical functional genes per allele coding together for α-globin chains *(→ a total of 4 α-coding genes, 2 paternal and 2 maternal, for the phenotype)*
Presence of the ζ-chain coding gene *(embryonal hemoglobins)*

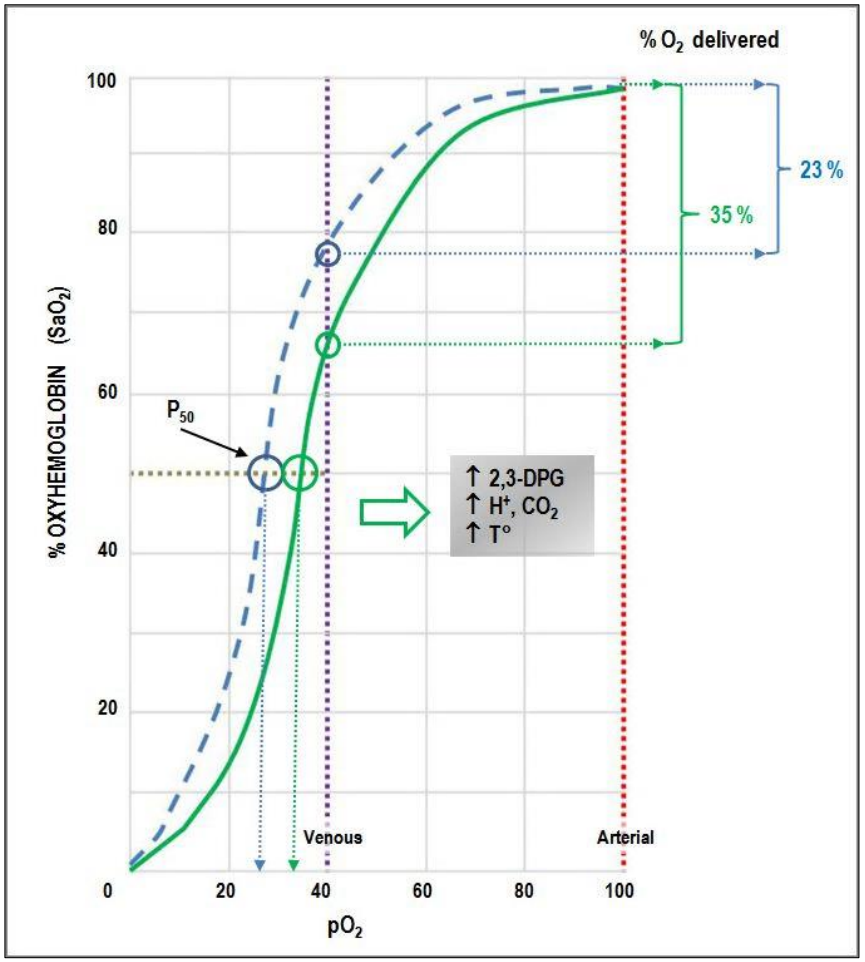
	GLOBIN STRUCTURE	HEMOGLOBIN
Embryonal hemoglobins	$\xi_2 \varepsilon_2$	Gower 1
	$\xi_2 \gamma_2$	Portland
	$\alpha_2 \varepsilon_2$	Gower 2
Adult hemoglobins	$\alpha_2 \beta_2$	A_1 (96 – 98%)
	$\alpha_2 \delta_2$	A_2 (1.5 – 3.0%)
	$\alpha_2 \gamma_2$	F (< 1%)



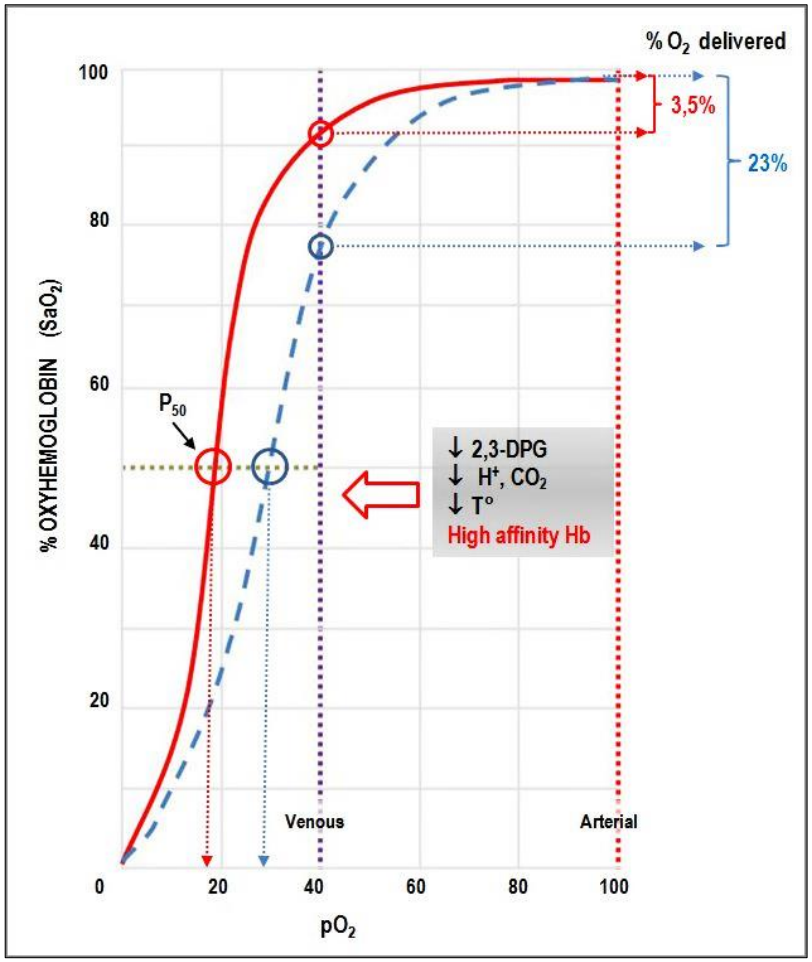
Synthesis of the various globin chains through ontogenesis

After : Wajcman H., Lantz B., Girot R. : les maladies du globule rouge 1992; Médecine-Sciences Flammarion : p. 12.

HEMOGLOBIN AFFINITY FOR OXYGEN



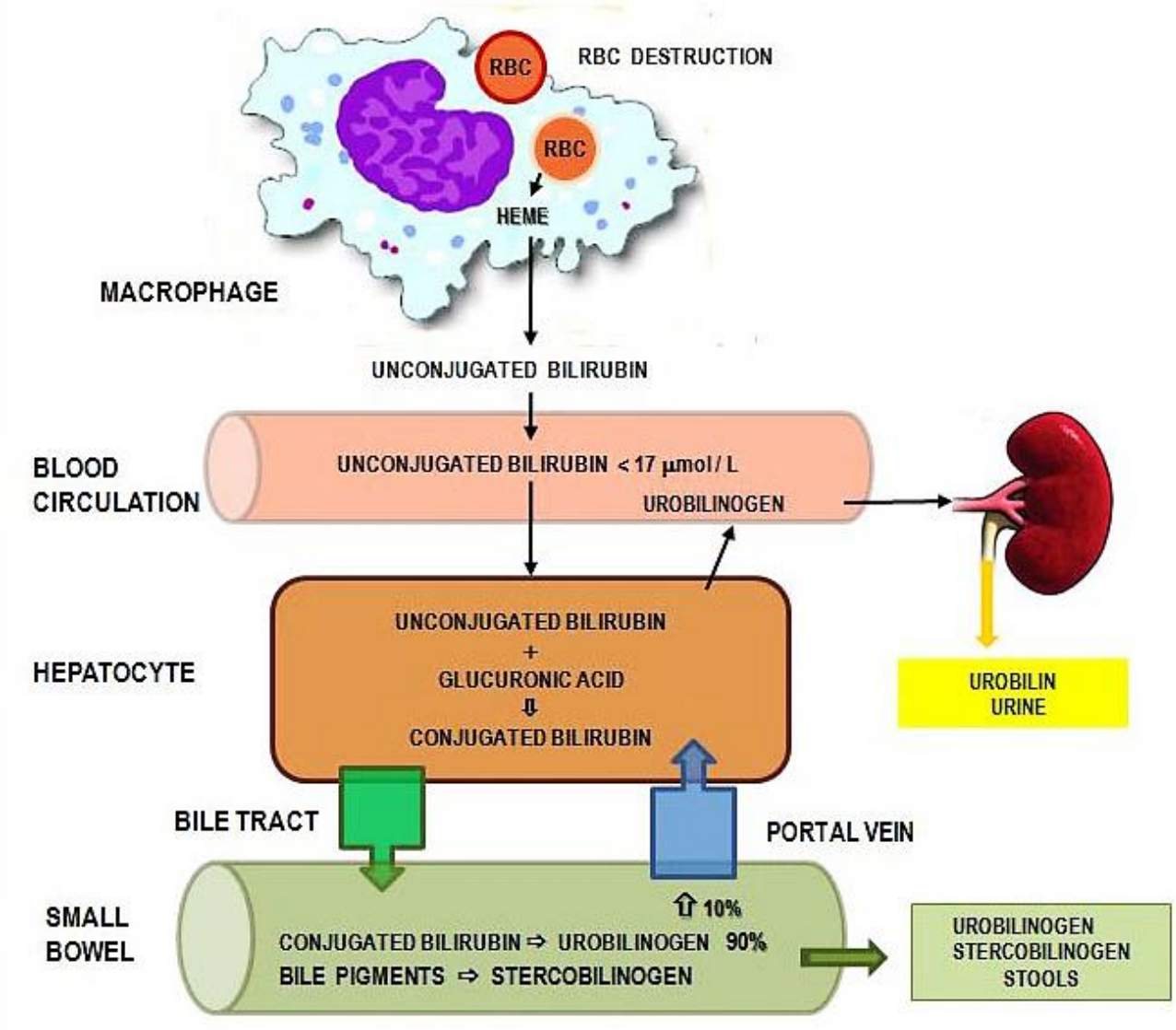
Right shift of the hemoglobin dissociation curve through
⇗ of 2,3-DPG : ⇘ of oxygen affinity of hemoglobin
In this situation : ***12% increase of O_2 tissues delivery***



Left shift of the hemoglobin dissociation curve through
⇘ of 2,3-DPG : ⇗ of oxygen affinity of hemoglobin
In this situation : ***20% diminution of O_2 tissues delivery***

Normal curve : – – – –

HEMOGLOBIN DEGRADATION



MACROCYTIC NORMOCHROMIC HYPOREGENERATIVE ANEMIA

MCV :	⇗	**> 99 fL**
MCH :	⇗	**> 34 pg**
MCHC :	**normal**	**310 – 360 g / L**
Reticulocyte count :		**< 120 G / L**

CLASSIFICATION

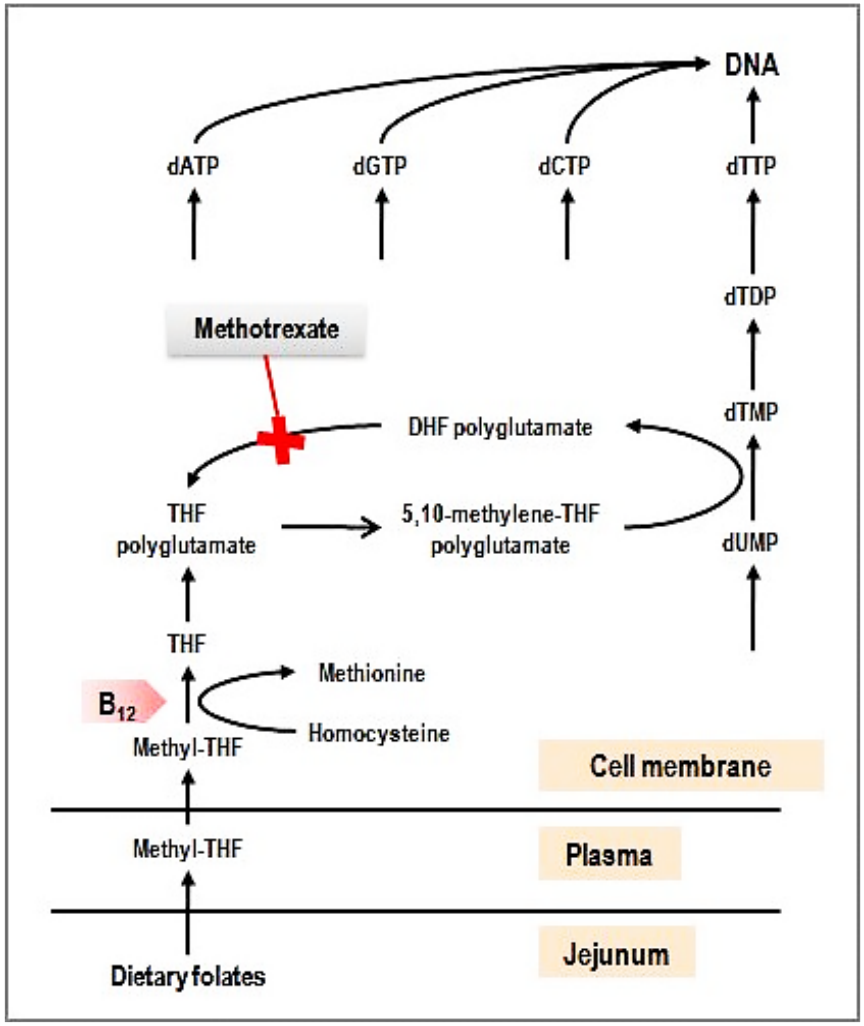
MEGALOBLASTIC MACROCYTIC ANEMIA

Vitamin B_{12} deficiency
Folate deficiency
Cytotoxic drugs
- *6-mercaptopurin*
- *5-fluorouracil*
- *Cytarabine*
- *Hydroxyurea*
- *Methotrexate*
- *Zidovudin (AZT)*

NON MEGALOBLASTIC MACROCYTIC ANEMIA

Alcoholism
Liver disease
Myxedema
Myelodysplastic syndrome

MEGALOBLASTIC MACROCYTIC ANEMIA
PATHOPHYSIOLOGY



Role of vitamin B_{12} (cobalamin) and folates in DNA metabolism

Methyl -THF :	*methyltetrahydrofolate*	*A :*	*adenine*
THF :	*tetrahydrofolate*	*G :*	*guanine*
DHF :	*dihydrofolate*	*C :*	*cytosine*
MP :	*monophosphate*	*T :*	*thymidine*
DP :	*diphosphate*	*U :*	*uridine*
TP :	*triphosphate*	*d :*	*deoxyribose*

Methionine deficiency might be the cause of myelin synthesis anomaly, leading to the neurological signs and symptoms found in vitamin B_{12} deficiency

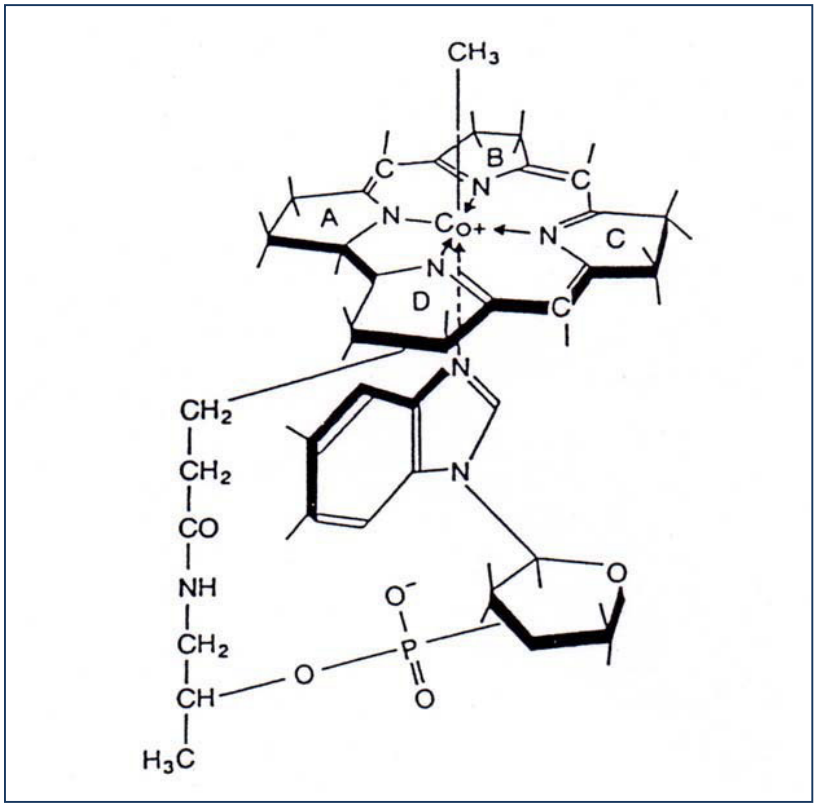
Other function of vitamin B_{12}

Propionyl-CoA $\xrightarrow{B_{12}}$ Methylmalonyl-CoA $\longrightarrow$ Succinyl-CoA

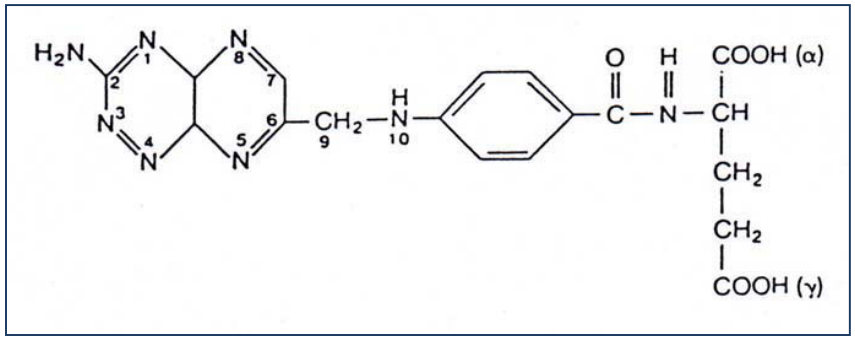
Vitamin B_{12} deficiency is responsible of homocysteine increase (cf. fig.) as of methylmalonic acid

Hoffbrand A.V., Moss P.A.H .: Essential Haematology, 6th edition 2011; Wiley-Blackwell Publishing : p. 63.

VITAMIN B_{12} AND FOLATES
CHEMICAL STRUCTURE



Structure of methylcobalamin *(plasma)*
Other compounds : deoxyadenosylcobalamin *(tissues)*, ***hydroxocobalamin and cyanocobalamin*** *(used in treatment of vitamin B_{12} deficiency)*



Structure of folic acid (pteroylglutamic acid) ***:*** **pteridine nucleus + para-aminobenzoic acid + glutamate(s)**

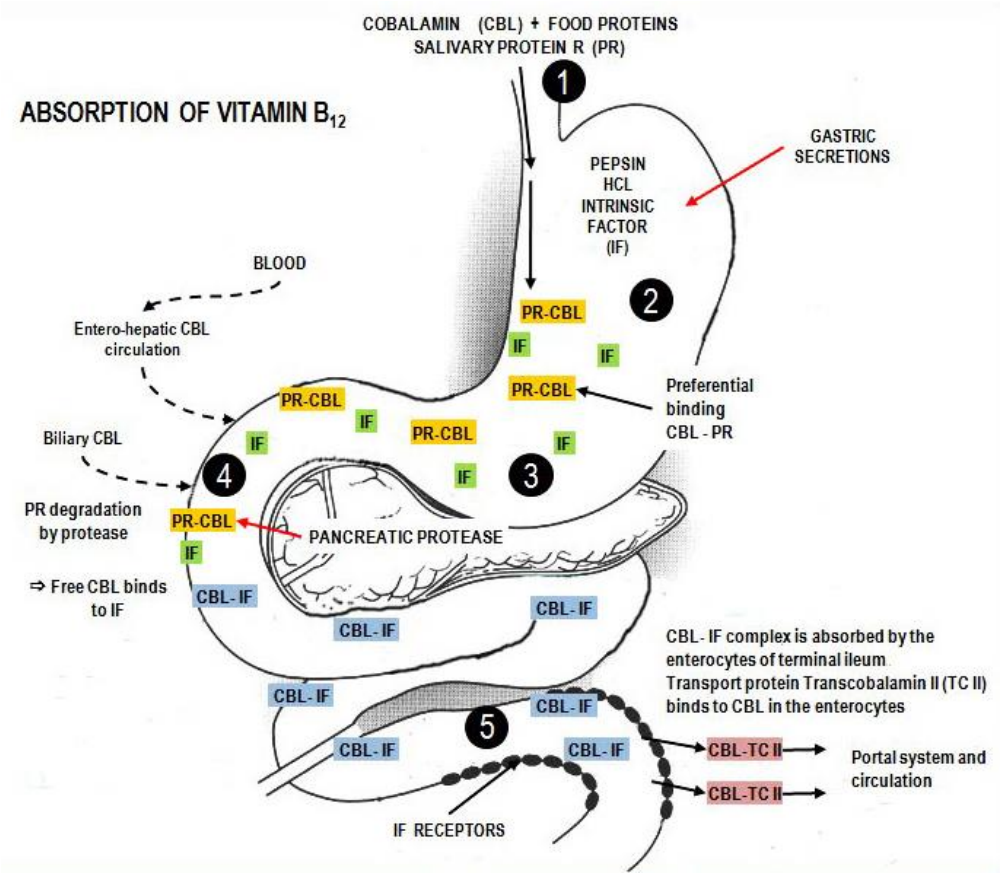
Hoffbrand A.V., Pettit J.E. : Essential Haematology, 3th edition 1993; Blackwell Science : p. 54 & 57.

VITAMIN B_{12} AND FOLATES
GENERAL DATA

	VITAMIN B_{12}	FOLATES
Balanced diet (/ day)	7 – 30 µg	200 – 250 µg
Daily needs	1 – 2 µg	100 – 150 µg
Origin	Animal	Vegetables, liver, yeast
Cooking (heat)	Few effect	Thermolabile
Stores	2 – 3 mg	10 – 12 mg
Exhaustion of stores	2-4 years	3-4 months
Absorption		
Site	Ileum	Jejunum
Mechanism	Intrinsic factor	Conversion to methyltetrahydrofolate
Transport	Transcobalamins (TC) TC I and III or haptocorrins or R proteins : Binding to food proteins then cobalamins transport TC II : transport and intracellular cobalamins transfer	Albumin
Active physiological forms	Methyl- and deoxyadenosylcobalamins	Polyglutamates
Compounds used for therapeutic substitution	Hydroxocobalamin Cyanocobalamin	Folic acid *(pteroylglutamic acid)*
Serum levels (physiological)	133 – 675 pmol / L[1]	7.0 – 45.1 nmol / L[1]

[1] LCC-CHUV, 2015

ABSORPTION OF VITAMIN B_{12}

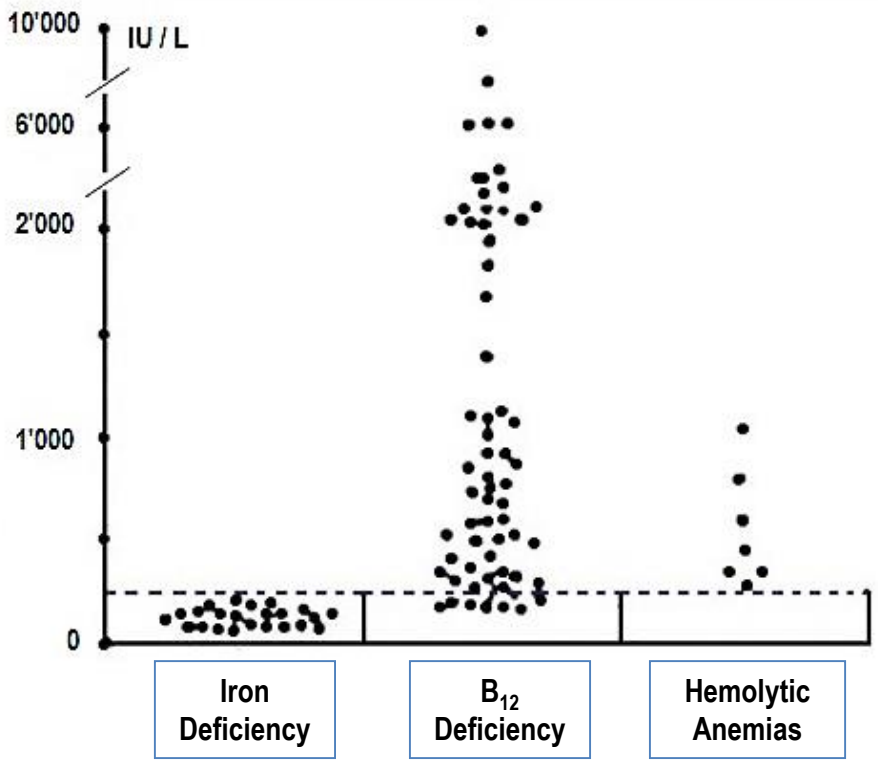


Cobalamins of dietary origin are bound unspecifically to the **food proteins.** In the stomach **peptic digestion at low pH** splits proteins from cobalamins which then bind to **R proteins** *(or haptocorrins)* of salivary origin. In the duodenum R proteins are degradated by pancreatic proteases which allows the **binding of cobalamins to the intrinsic factor of gastric origin.** The **ileal receptor** of the vitamin B_{12} / IF complex is the **cubulin**
TC I and TC III are abundant in the secondary granules of neutrophils

PHYSIOPATHOLOGICAL MECHANISMS OF VITAMIN B_{12} (COBALAMIN) DEFICIENCY

1. **Cobalamin dietary deficiency**
2. **Anomaly of cobalamin - food dissociation**
3. **Quantitative or qualitative defect of Intrinsic Factor (IF)**
4. **Deficiency of pancreatic protease**
   Abnormal utilization of vitamin B_{12} by bacterias *(blind loop syndrome),*
   fish worm *(diphyllobothrium latum)*
5. **Anomaly of ileal mucosa and / or of the IF receptors and / or transfer in the enterocyte**

LDH AND ANEMIA



LDH activity in iron deficiency, megaloblastic and hemolytic anemias
Dotted line : upper limit of the reference interval

Modified from Emerson P.M., Wilkinson J.H., Br J Haematol 1966; 12 : 678-688.

MEGALOBLASTIC ANEMIA WITH DNA SYNTHESIS ANOMALY

Nuclear maturation slowdown
Reduction of the number of mitosis
Optimal hemoglobin concentration reached before the usual 4 mitosis
Increased size of the cells
Bone marrow : *megaloblasts*
Peripheral blood : *megalocytes ("macroovalocytes")*
Intramedullary and peripheral hemolysis
Bone marrow with megaloblastic hyperplasia by erythroid stem cell recruitment through erythropoietin

SCHILLING TEST

Saturation of transcobalamins by IM injection of 1 mg vitamin B_{12}
Oral administration of 0.5 -1 µg radiolabeled vitamin B_{12}
48 hours urine collection and measure of excreted radioactivity
In case of pathological result repeat the test with concomitant oral intrinsic factor administration (IF)

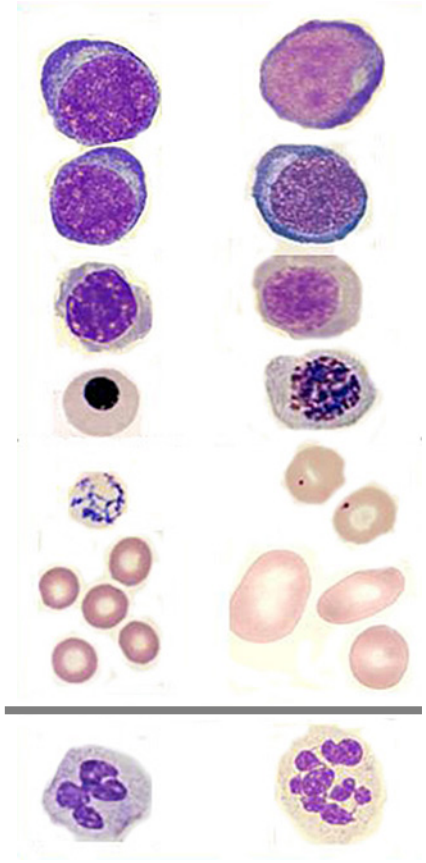
	Urinary excretion of radiolabeled vitamin B_{12} (%)	
	B_{12} alone	B_{12} + IF
Normal subject	**18 (9 – 36)**	**–**
Pernicious anemia	**0.5 (0 – 1.2)**	**13 (6 – 31)**
Malabsorption (gluten enteropathy)	**3.6 (0 – 19)**	**3.3 (0 – 10)**

Results obtained with 0.5 µg of radiolabeled oral vitamin B_{12}. *This test is nowadays less performed. In some countries radioactive labelled vitamin B_{12} is no more commercially available. The test is still mentioned in this synopsis for educational reasons*

Modified from Lee G.R., Wintrobe's Clinical Hematology, 9th edition 1993; Lea & Febiger : p. 776.

NORMAL AND MEGALOBLASTIC ERYTHROPOIESIS

	NORMAL ERYTHROPOIESIS	MEGALOBLASTIC ERYTHROPOIESIS
BONE MARROW		
CELLULARITY	NORMAL	INCREASED
PROERYTHROBLASTS		
EARLY ERYTHROBLASTS		
INTERMEDIATE ERYTHROBLASTS		
LATE ERYTHROBLASTS		
BLOOD — RETICULOCYTES		
RED BLOOD CELLS		
WHITE BLOOD CELLS		
NEUTROPHILS		



MEGALOBLASTS (Asynchronism of nucleocytoplasmic maturation)

NORMAL HEMOGLOBIN SYNTHESIS

HOWELL-JOLLY BODIES
LOW OR ABSENT RETICULOCYTES

MACROCYTES
MEGALOCYTES

HYPERSEGMENTED NEUTROPHILS

Modified from Chandrasoma P., Taylor C.R. : Concise Pathology, 3th edition 1998; Appleton & Lange.

CAUSES OF VITAMIN B_{12} DEFICIENCY

MALABSORPTION

Gastric origin :

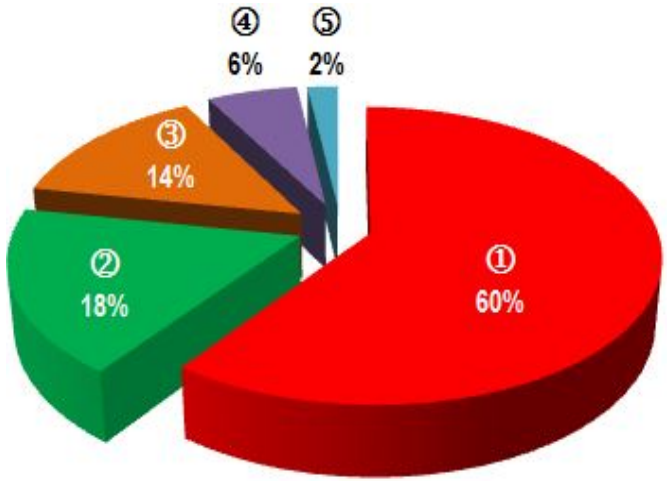
Achlorhydria
Pernicious anemia
Partial or total gastrectomy
Congenital intrinsic factor deficiency

Intestinal origin :

Resection of terminal ileum
Crohn's disease
Gluten induced enteropathy
Fish tapeworm (Diphyllobothrium latum) infestation

Dietary deficiency

Distribution of causes of vitamin B_{12} deficiency in adults



① Non dissociation of vitamin B_{12} from its transport proteins or insufficient digestion of nutritional vitamins B_{12}
② Pernicious anemia
③ Unknown cause
④ Malabsorption
⑤ Nutritional deficiency

After : Andrès E. et al. : Hématologie 2007; 13 : 186-192.

PERNICIOUS ANEMIA

PATHOPHYSIOLOGY

Atrophic gastritis of immune origin with lack of intrinsic factor

HEMATOLOGY

Macrocytic megaloblastic anemia
Neutropenia with hypersegmented neutrophils
Thrombocytopenia

CLINICAL ASPECTS

Atrophic glossitis *(Hunter's glossitis)***, dyspepsia**
Combined degeneration of the dorsal *(posterior)* **and lateral spinal columns** *(paresthesias, pain, gait disturbance, pallesthesia diminution, pyramidal syndrome)*
→ *Methionine synthesis defect ?*
Psychiatric symptoms *(irritability, depression)*
Melanic skin hyperpigmentation *(uncommon !)*
Sterility, asthenospermia

PERNICIOUS ANEMIA (2)
LABORATORY

LABORATORY TESTS

- ⇗ **Methylmalonic acid *(plasma).* Normal range : < 0.28 µmol / L[1]**
- ⇗ **Homocysteine *(plasma).* Normal range : 5 − 15 µmol / L[1]**
- ⇘ ***Holotranscobalamin : 10 – 30% of biologically active vit. B_{12} [might be more specific of deficiency than total B_{12}*** *(70-90% being inactive through binding to haptocorrins)]*

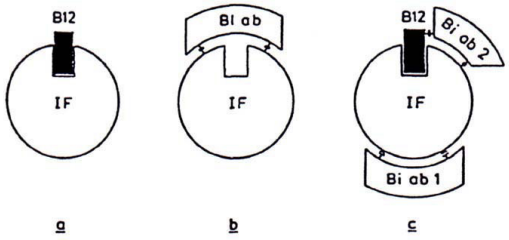
SCHILLING TEST

Pathological but normalized after simultaneous administration of vitamin B_{12} + intrinsic factor

ANTIBODY SCREENING

	Antiparietal cells (± 90%) [1]	Anti-intrinsic factor (± 50%)
Specificity	**–**	**+**
Sensitivity	**+**	**–**

[1] Antiparietal cells antibodies can be found in normal individuals (5-20%) and in myxedema (~ 30%)

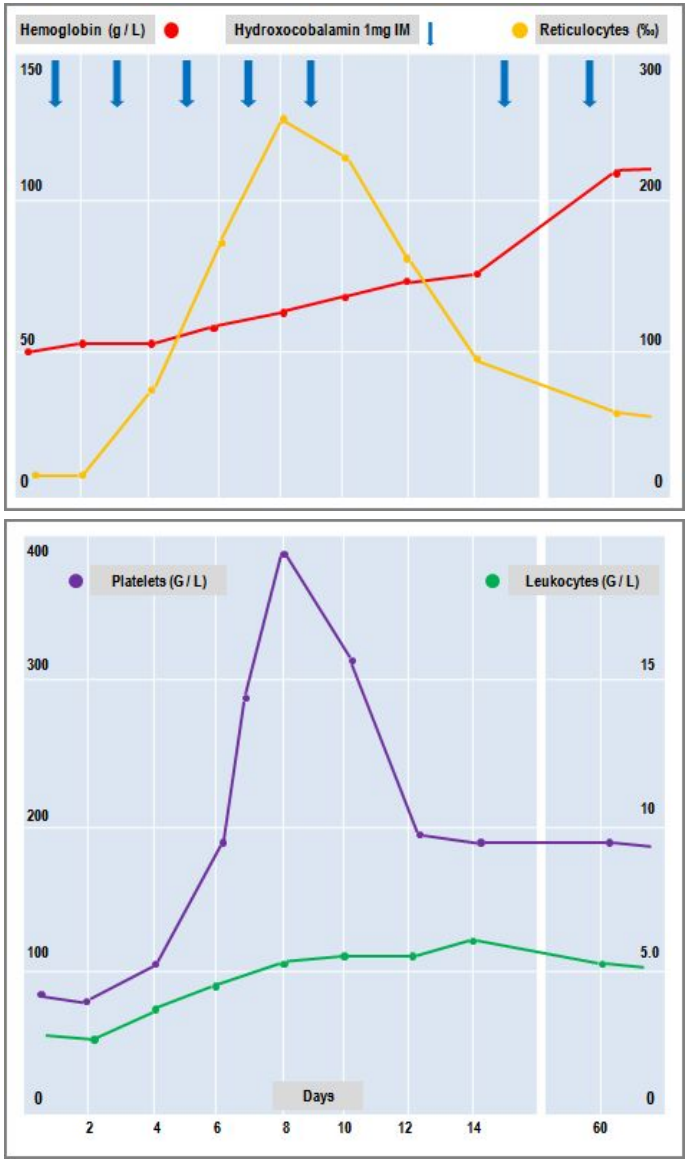


Schematic presentation of intrinsic factor (IF), vitamin B_{12} and of antibody directed against intrinsic factor :
a) Normal binding between IF and vitamin B_{12}
b) Blocking antibody
c) Coupling antibody

[1] LCC-CHUV, 2015

Modified from Lee G.R. : Wintrobe's Clinical Hematology, 9th edition 1993; Lea & Febinger : p. 753.

PERNICIOUS ANEMIA (3)
RESPONSE TO HYDROXOCOBALAMIN SUBSTITUTION



After systemic application of Hydroxocobalamin

- **Bone marrow becomes normoblastic within 48 hours**
  Persistance of giant metamyelocytes up to 12 days *(even longer)*

Because of duration of hematopoietic lineages maturation :

- **6th – 10th day, reticulocytes increase** *(«reticulocyte peak»)*, **normalisation of platelet and leucocyte counts if previously lowered**
- **Normalisation of hemoglobin level after 2 months only**

Modified from Hoffbrand A.V., Moss P.A.H.. : Essential Haematology, 6th edition 2011; Wiley-Blackwell Publishing : p 70.

CAUSES OF FOLATE DEFICIENCY

DIETARY DEFICIENCY

MALABSORPTION

Gluten induced enteropathy
Wide jejunal resection
Crohn's disease

INCREASED DEMAND

Physiological : *Pregnancy*
Lactation
Prematurity
Growth

Pathological : *Hemolytic anemia*
Cancer, myeloid or lymphoid neoplasm
Inflammatory process

DRUGS

Anticonvulsants (e.g. : Diphenylhydantoin)
Barbiturates
Salazopyrin

ALCOHOLISM

WORKUP OF MACROCYTIC ANEMIA
WITH OR WITHOUT NEUTROPENIA AND / OR THROMBOCYTOPENIA

1. **RETICULOCYTE COUNT**

   Regenerative anemia ?

2. **FOLATES AND VITAMIN B_{12} SERUM LEVELS**

   DNA synthesis disorder ?

3. **TESTS OF THYROID FUNCTION**

   Hypothyroidism ?

4. **ALCOHOLISM INVESTIGATION**

5. **IF 1-4 NEGATIVE → BONE MARROW CYTOLOGY AND HISTOLOGY**

   Myelodysplastic syndrome ?
   Bone marrow aplasia ?

NORMOCYTIC NORMOCHROMIC REGENERATIVE ANEMIA

MCV :	normal	81 – 99 fL
MCH :	normal	27 – 34 pg
MCHC :	normal	310 – 360 g / L
Reticulocyte count :		> 120 G / L

ACUTE BLOOD LOSS

BLOOD LOSS	% BLOOD VOLUME	SYMPTOMS
0.5 – 1.0 L	10 – 20	Possible vaso-vagal reaction
1.0 – 1.5 L	20 – 30	Tachycardia / hypotension
1.5 – 2.0 L	30 – 40	Reversible hypovolemic shock
> 2.0 L	> 40	Irreversible hypovolemic shock

ACUTE BLOOD LOSS (2)

Evolution in 2 phases :

1. **Hypovolemia (1-3 days)**
2. **Volemia normalization**

Anemia is only found during phase of volemia correction

Anemia is normocytic normochromic as far as iron stores are not exhausted

1 L of blood = 500 mg of iron

Reticulocyte count increases from the 4th day, possibly neutrophilic leukocytosis with left shift, myelocytosis *(presence of some peripheral blood myelocytes and metamyelocytes)*, **thrombocytosis**

Treatment :

Phase 1 : ***Packed red cells and plasma***
Phase 2 : ***Packed red cells***

HEMOLYTIC ANEMIA
BASIC DATA

HISTORY

Ethnic origin, family history
Stay in a foreign country
Drug treatment
Prior transfusion(s), pregnancy(-ies)

CLINICAL FEATURES

Jaundice
Splenomegaly

HEMOGRAM

Normocytic normochromic anemia

Particular situations :

Absence of anemia in case of compensated hemolysis
Microcytic anemia : thalassemia, hemoglobinopathies E, C, PNH[1]
Macrocytic anemia : high reticulocyte count, associated folate deficiency

Regeneration signs

Polychromasia
Increased reticulocyte count
Presence of peripheral blood erythroblasts

Red blood cell morphology

Spherocytes, schistocytes, sickle cells, target cells

[1] PNH : Paroxysmal Nocturnal Hemoglobinuria (iron deficiency due to chronic hemoglobinuria)

HEMOLYTIC ANEMIA
BASIC DATA (2)

BLOOD CHEMISTRY

- ⇗ **unconjugated bilirubin**
- ⇗ **L D H**
- ⇘ **haptoglobin**
- ⇗ **fecal stercobilinogen**
- **Urobilinuria**

ISOTOPIC TESTS

RBC ½ life *(test nowadays less performed)*

EXTRAVASCULAR HEMOLYSIS

"Sensitization" of circulating RBC and destruction by the monocyte / macrophage system
(*spleen, liver, lymph nodes, bone marrow)*

INTRAVASCULAR HEMOLYSIS

- ⇗ **plasmatic Hb** *(> 50 mg / L)*
- **Hemoglobinuria**
- **Hemosiderinuria**

HEMOLYSIS DUE TO CORPUSCULAR ANOMALY

Hereditary *(except PNH[1])*
Homozygous or heterozygous

HEMOLYSIS DUE TO EXTRACORPUSCULAR ANOMALY

Acquired

[1] PNH : Paroxysmal Nocturnal Hemoglobinuria

HEMOLYTIC ANEMIA DUE TO CORPUSCULAR DEFECT

ENZYMOPATHY

RBC MEMBRANE DISORDER

HEMOGLOBIN DISORDER

Diminution (or absence) of globin chains synthesis

THALASSEMIAS *(cf. p. 76-79)*

Substitution (or deletion) of a residue on a globin chain (> 1'000 anomalies)

SICKLE CELL DISEASE

HEMOGLOBINS E, C

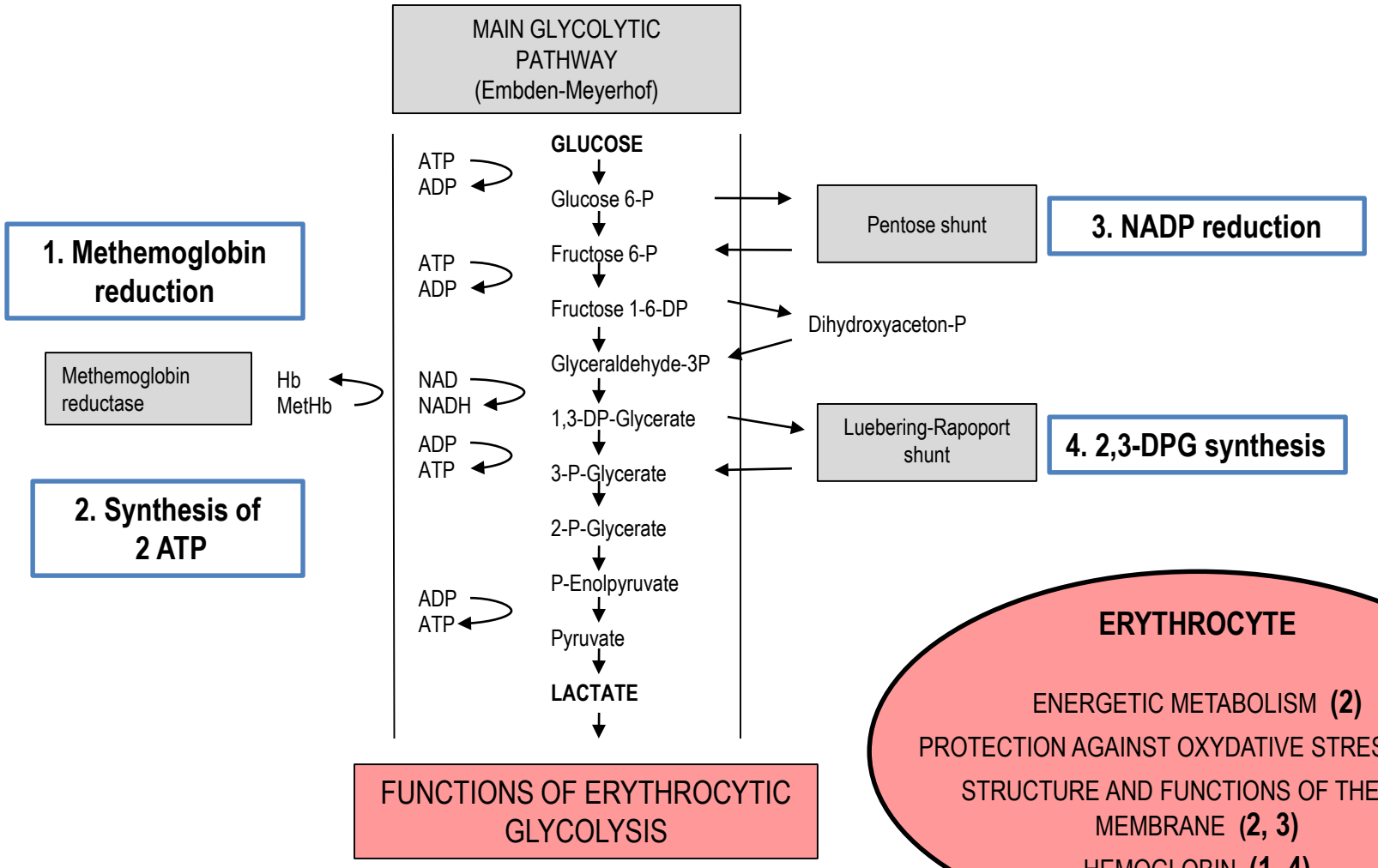
UNSTABLE HEMOGLOBINS

HEMOGLOBINS M[1]

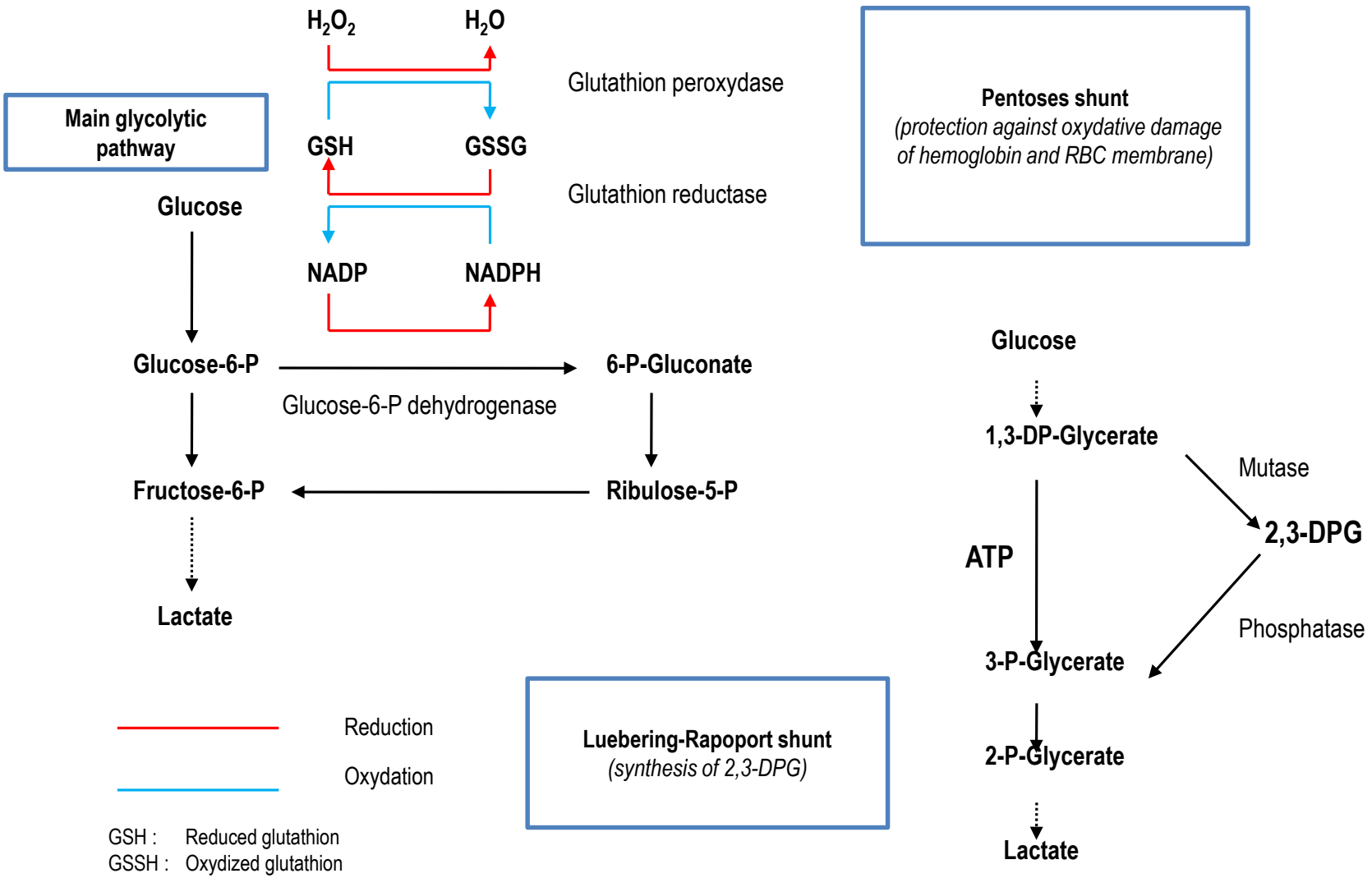
HEMOGLOBINS WITH INCREASED OR REDUCED OXYGEN AFFINITY

[1] M : Methemoglobin

GLYCOLYSIS OF RED BLOOD CELLS



GLYCOLYSIS OF RED BLOOD CELLS (2)



GSH : Reduced glutathion
GSSH : Oxydized glutathion

RED BLOOD CELL ENZYMOPATHY

FREQUENT

PENTOSE SHUNT

Glucose-6-phosphate dehydrogenase *(G-6-PD)* ***deficiency***
(> 400 .10^6 cases, > 300 variants)

EMBDEN-MEYERHOF PATHWAY

Pyruvate kinase deficiency *(< 1'000 cases)*
Glucose phosphate isomerase deficiency *(< 200 cases)*

UNCOMMON

EMBDEN-MEYERHOF PATHWAY

Deficiency in : ***Hexokinase, phosphofructokinase, aldolase, triose phosphate isomerase, diphosphoglycerate mutase, phosphoglycerate kinase***
(< 20 cases)

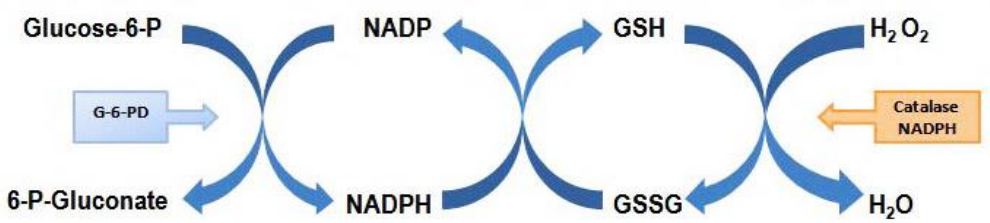
GLUCOSE-6-PHOSPHATE DEHYDROGENASE DEFICIENCY (G-6-PD)

X-linked recessive deficiency

Hemolysis :
Chronic (uncommon), usually induced by : drugs, fever, fava beans (Favism)

Amino acid substitution in some variants of G-6-PD

Variants	Position of residue				
	68	126	188	227	323
B (+)	Valine	Asparagine	Serine	Arginine	Leucine
A (+)		Aspartic acid			
A (-)	Methionine				
A (-)				Leucine	
A (-)					Proline
Mediterranean			Phenylalanine		



B (+) : Physiological form, predominant

A (+) : Physiological form, 30% African colored

A (-) : 11% African American, activity 5-15% of normal

Mediterranean *[formerly B (-)]* **: *Activity < 1%***

Reduced glutathione (GSH) protects the -SH groups of the RBC membrane and hemoglobin

During hemolytic crisis, presence of *Heinz bodies* **in the RBC after staining with brilliant cresyl blue = denatured hemoglobin** *(oxidized)*

Decrease in hemolysis during reticulocyte response *(young RBC contain more enzyme than mature RBC)*

GLUCOSE-6-PHOSPHATE DEHYDROGENASE DEFICIENCY (G-6-PD) (2)

Main triggers of hemolytic crisis in G-6-PD deficiency[1]

ANTIMALARIAL DRUGS

Primaquine, pamaquine, pentaquine, quinine

SULFONAMIDES

Sulfacetamide, sulfamethoxazole, sulfanilamide, sulfapyrine, sulfoxone, thiazosulfone

ANTIBIOTICS AND BACTERIOSTATIC AGENTS

Para-aminosalicylic acid, nalidixic acid, nitrofurantoin, chloramphenicol, methylene blue, niridazole

ANALGESICS

Acetanilide, amidopyrine, paracetamol

OTHERS

Toluidin blue, naphtalene, phenylhydrazine, probenecid, trinitrotoluen

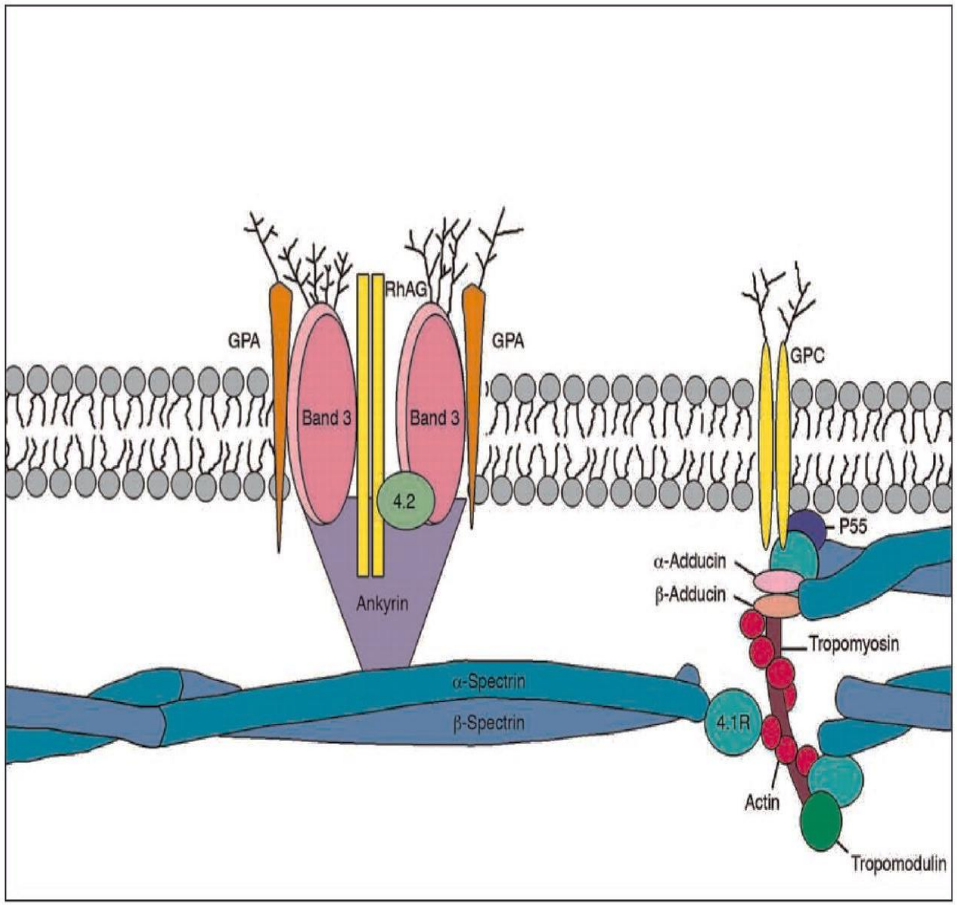
FOOD

Beans *(fava beans…)*

[1] Because of disease polymorphism, these substances are not necessarily dangerous for all G-6-PD deficient subjects. Nevertheless they should be avoided because of the unpredictable tolerance of each subject

Modified from Wajcman H., Lantz B., Girot R. : Les maladies du globule rouge 1992; Médecine-Sciences Flammarion : p. 262.

STRUCTURE OF RED BLOOD CELL MEMBRANE



Composite structure with double layer lipidic membrane anchored to a two-dimensional elastic network **(cytoskeleton)** with tethering sites (transmembrane proteins)

Vertical fixation involves the cytoplasmic domain of **Band 3** protein**, Ankyrin, Protein 4.2** and **Spectrin**

Horizontal interaction involves **Spectrin** (α- and β-chains), with **Protein 4.1R, Actin, Tropomodulin, Tropomyosin** and **Adducins**

Protein 4.1R interacts also with the transmembrane **Glycophorin C (GPC)** and protein P55 in a triangular mode

GPA : Glycophorin A
RhAG : Rhesus Antigen

ANOMALY OF RED BLOOD CELL MEMBRANE

HEREDITARY SPHEROCYTOSIS

AUTOSOMAL DOMINANT *(cf. next pages)*

AUTOSOMAL RECESSIVE *(frequent in Japan; protein 4.2 mutations)*

AUTOSOMAL DOMINANT WITH ACANTHOCYTOSIS

HEREDITARY ELLIPTOCYTOSIS

Anomaly of spectrin, protein 4.1

HEREDITARY STOMATOCYTOSIS

ABETALIPOPROTEINEMIA WITH ACANTHOCYTOSIS[1]

[1] **Not to be mistaken for acanthocytosis secondary to severe liver disorder**

HEREDITARY SPHEROCYTOSIS
AUTOSOMAL DOMINANT

PATHOPHYSIOLOGY

Anomalies of spectrin, ankyrin, band 3, which may be combined
Spherocytes with loss of plasticity and splenic trapping *(sequestration)*

- ***Volume usually normal***
- ***Diameter*** ⇩
- ***Surface*** ⇩

Increase of membrane permeability for Na^+ *(⇗ glycolytic activity)*

CLINICAL FEATURES

Chronic hemolytic anemia

- ⇗ **if :** **pregnancy**
  exercise
  intercurrent viral infection *(EBV, etc.)*

Splenomegaly
Negative Coombs test
⇘ **osmotic resistance**
⇗ **autohemolysis, corrected by glucose**
Pure splenic RBC destruction
Aplastic crises *(Parvovirus B19)*
Frequent cholelithiasis

TREATMENT

Splenectomy *(severe forms only)*

AUTOSOMAL DOMINANT HEREDITARY SPHEROCYTOSIS (2)

Clinical classification of hereditary spherocytosis (HS)

	Trait	Light HS	Moderate HS	Moderate to severe HS[1]	Severe HS[1]
Hb (g / L)	Normal	110 – 150	80 – 120	60 – 80	< 60
Reticulocyte count (‰)	1 – 30	30 – 80	≥ 80	≥ 100	≥ 100
Spectrin content[2] (% of normal)	100	80 – 100	50 – 80	40 – 80	20 – 50
Spherocytes	-	+	+	+	+ with poikilocytosis
Osmotic resistance	normal	normal / ↘	↘↘	↘↘	↘↘
Autohemolysis	slightly ↗	↗↗	↗↗	↗↗	↗↗↗
Splenectomy *(indication)*	–	–	– / +	+	+

[1] Values in absence of transfusion. Patients with severe HS are transfusion dependent

[2] Reference values (± SD) : 245 ± 27 x 10^5 spectrin dimers / RBC
In most patients ankyrin content is reduced in parallel. A low number of patients lack band 3 or protein 4.2; in this situation HS is light to moderate with normal amounts of spectrin and ankyrin

Modified from Eber S.W., Armbrust R., Schröter W., J Pediatr 1990; 117 : 409-416, & Pekrun A., Eber S.W., Kuhlmey A., Schröter W., Ann Hematol 1993; 67 : 89-93.

PAROXYSMAL NOCTURNAL HEMOGLOBINURIA (PNH)
PATHOPHYSIOLOGY

Mutation of a gene on chromosome X coding for the glycosyl phosphatidyl inositols *(membrane anchoring proteins)* **named PIGA** *(= Phosphatidyl Inositol Glycan complementation class A)*
with deficiency of membrane anchor proteins

3 types of RBC :

PNH I :	**normal**
PNH II :	**intermediate**
PNH III :	**abnormal**

RBC lysis by complement due to membrane protein anomalies like :

CD55 :	**Decay Accelerating Factor (DAF)**
CD59 :	**Membrane Inhibitor of Reactive Lysis (MIRL) / Homologous Restriction Factor (HRF)**

Clonal anomaly of hematopoietic stem cell

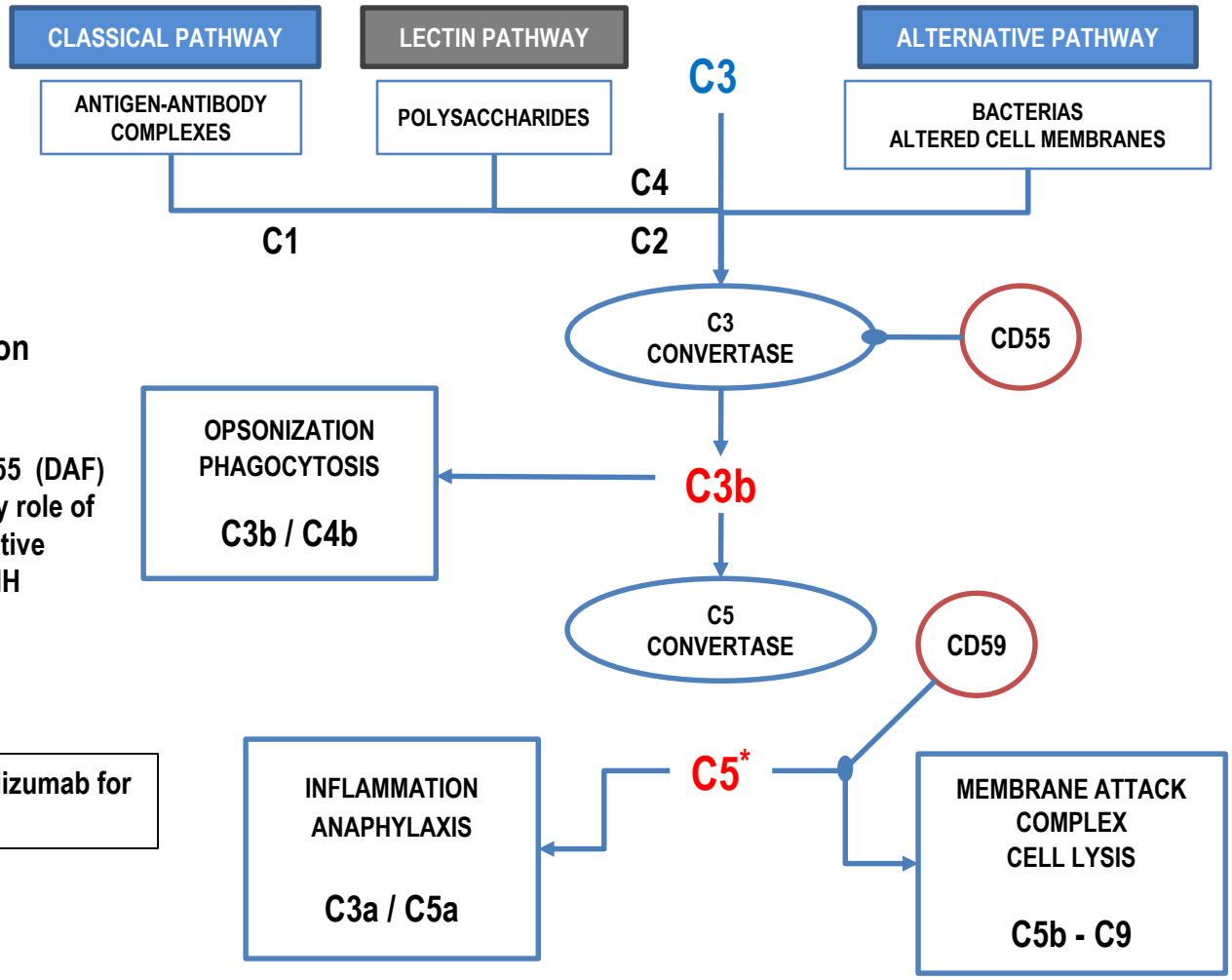
Lysis affects also neutrophils and platelets which also present functional anomalies

Relation with aplastic anemia

PAROXYSMAL NOCTURNAL HEMOGLOBINURIA (PNH) (2)

Outline of the complement activation pathways *(classical and alternative)*

The 2 membrane regulatory proteins CD55 (DAF) and CD59 (MIRL / HRF) play an inhibitory role of the complement activation by the alternative pathway. They are missing on RBC in PNH



* Target for monoclonal antibody Eculizumab for treatment of PNH

PAROXYSMAL NOCTURNAL HEMOGLOBINURIA (PNH) (3)

CLINICAL FEATURES

Hemolytic anemia with hemoglobinuria *(nocturnal)*

↘ **of pH during sleep ?** *(controversial)*

Depending on the size of the PNH III clone. Promoted by infections, surgery, violent exercise, alcohol, transfusions

Splenomegaly

Thromboembolic manifestations *(Budd-Chiari syndrome : thrombosis of hepatic veins)*

Median survival : **14.6 years** *(Socié G. et al., Lancet 1996; 348 : 573-577.)*

Causes of death : **Thromboses**
Hemorrhage

Possible evolution : **Aplastic anemia**
Acute leukemia

DIAGNOSIS

Immunophenotyping : **Deficiency(-ies) of CD55 (DAF), CD59 (MIRL / HRF), CD58 (LFA-3) on *RBC;***
CD55, CD59, CD58, CD16, CD24 and CD66b on *neutrophils :* markers anchored on the cellular membrane through Glycosyl Phosphatidylinositols *(GPI-linked)*

FLAER test *(Sutherland D.R. et al., Cytometry Part B (Clinical Cytometry) 2007; 72B : 167-177 and Am J Clin Pathol 2009; 132 : 564-572.)*

Ham-Dacie test *(acid test[1])*

Sucrose test[1]

TREATMENT

Transfusion

Eculizumab *(monoclonal antibody anti-C5)*

Iron substitution if deficiency *(may increase hemolysis by stimulation of PNH III clone)*

Allogeneic stem cell transplantation *(ev. bone marrow)* **in severe cases**

[1] These tests are obsolete and should be replaced by immunophenotyping

GENETIC ANOMALIES OF HEMOGLOBIN - HEMOGLOBINOPATHIES
CLASSIFICATION

Structure anomalies of globin chains

- **Hemoglobin S** *(sickle cell disease)*
- **Hemoglobin C**

Reduced synthesis of normal globin chains

- **Thalassemia syndromes**
  - **α-thalassemia**
  - **β-thalassemia**
  - **δβ-thalassemia**
- **Variants of thalassemic hemoglobins**
  - **Hemoglobin E, hemoglobin Lepore, hemoglobin Constant-Spring, etc.**

Combined anomalies

- **Thalassemic syndrome + Hemoglobin S or C**
- **Combination of 2 different thalassemic syndromes**

GENETIC ANOMALIES OF HEMOGLOBIN (2)
HEMOGLOBINOPATHIES

THALASSEMIC SYNDROMES : cf. following pages

α-thalassemia
β-thalassemia
δβ-thalassemia
Hereditary persistance of hemoglobin F

Microcytic anemia of variable importance

SICKLE CELL DISEASE (Hb S) : *(cf. p. 80-81)*

HEMOGLOBIN E
β26 Glu → Lys

Microcytic anemia with target cells

HEMOGLOBIN C
β6 Glu → Lys

Microcytic anemia with target cells

UNSTABLE HEMOGLOBINS
Hb Zurich (β63 His → Arg)

Hemolysis with Heinz bodies after intake of oxydizing drugs

HEMOGLOBINS M

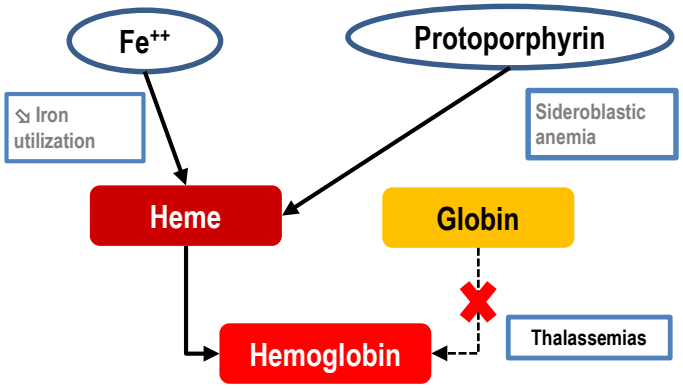
Cyanosis due to methemoglobinemia

HEMOGLOBINS WITH INCREASED OR REDUCED OXYGEN AFFINITY

ANOMALY	GEOGRAPHICAL DISTRIBUTION	CARRIERS (10^6)
Hemoglobin S *(Sickle cell anemia)*	Africa, Afro-americans India, Pakistan, Mediterranean regions	50 10
Hemoglobin C	West Africa	8 -10
Hemoglobin E	Southwest Asia	30-50
α / β - thalassemias	Asia Europe Other regions	90 5 3

THALASSEMIC SYNDROMES
PHYSIOPATHOLOGY

DISORDER OF GLOBIN SYNTHESIS



Molecular heterogeneity :

DNA alteration mostly through deletion(s) :

α-thalassemia : ↘ or absence of globin α-chain synthesis

DNA alteration mostly through point mutation(s)

β-thalassemia : ↘ or absence of globin β-chain synthesis

δβ-thalassemia : ↘ of β- and δ-globin chains synthesis with ↘ Hb A_1 and A_2, ↗ Hb F

Hereditary persistence of Hb F : idem δβ-thalassemia + ↗ production of γ-globin chains

CENTRAL *(BONE MARROW)* AND PERIPHERAL HEMOLYSIS THROUGH INSTABILITY OF THE TETRAMERS

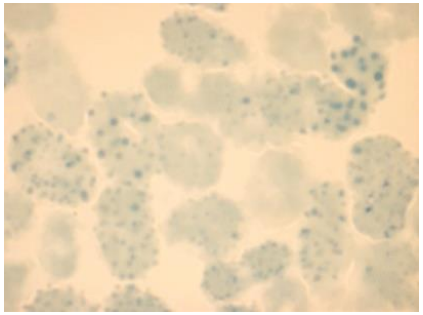
α_4 for β-thalassemia

β_4 for α-thalassemia *(Hemoglobin H)*

α-THALASSEMIA

Mutations leading to α-thalassemia are mostly deletion(s) of one or more of the 4 genes coding for globin α-chain on chromosome 16

GENOTYPE	PHENOTYPE	CLINIC	TREATMENT
αα / αα	**Normal**	∅	
- α / αα	**α^+ thalassemia** *(heterozygosity)*	**Asymptomatic** *(frequently MCV < 80 fL)*	∅
- - / αα	**α^0 thalassemia** *(heterozygosity)*	**Thalassemia minor**	∅
- α / - α	**α^+ thalassemia** *(homozygosity)*	**Thalassemia minor**	∅
- - / - α	**α^0 / α^+ thalassemia** *(double heterozygosity)*	**Thalassemia intermediate** *Hemoglobine H (β_4)*	Regular transfusions Iron chelation / folates Splenectomy ASCT[1]
- - / - -	**α^0 thalassmia** *(homozygosity)*	**Hydrops foetalis** *Bart's hemoglobin (γ_4)*	Intrauterine death



Inclusion bodies
(Hemoglobin H : β_4 precipitates)

DIAGNOSIS :

Search of inclusion bodies *: after brilliant cresyl blue staining of RBC → "golf ball" images*

Hemoglobin electrophoresis of fresh hemolysate[2] at alcaline or neutral pH. Isoelectric focusing *(Hb H)*

HPLC *(High Performance Liquid Chromatography)*

DNA analysis necessary for minor forms, undisclosed by hemoglobin electrophoresis *(absence Hb H)*

[1] ASCT : allogeneic stem cell transplantation

[2] Hemoglobin H is unstable

β-THALASSEMIA

β-thalassemias are mostly due to point mutation(s) in the complex of the β-globin gene, but also outside of the complex [promoter or regulator gene(s) on chromosome 11]

GENOTYPE	PHENOTYPE	LABORATORY	CLINIC	TREATMENT
β / β	**Normal**		∅	
β / $β^{+\ thal}$ or β / $β^{0\ thal}$	**β - thalassemia** *(heterozygosity)*	Hb ≥ 100 g / L Frequent micropolyglobulia i.e : *Hb : 105 g / L Ery : 6.2 T / L, MCV : 62 fL* Target cells, basophilic stippling Hemoglobin electrophoresis : Hb A_2 ⇗ / Hb F ⇗ ou ⇔	**Thalassemia minor**	∅ Genetic counseling
$β^{+\ thal}$ / $β^{+\ thal}$	**$β^{+}$ - thalassemia** *(homozygosity)*	Hb 70 – 100 g / L *Microcytosis* *Grade depends on residual globin β-chain synthesis*	**Thalassemia intermedia**	Transfusion requirements less than for thalassemia major
$β^{0\ thal}$ / $β^{+\ thal}$	**β - thalassemia** *(double heterozygosity)*		**Thalassemia intermedia or major[1]**	Regular transfusions Iron chelation / folates Splenectomy ASCT[2]
$β^{0\ thal}$ / $β^{0\ thal}$	**$β^{0}$- thalassemia** *(homozygosity)*	✩ *or absence of Hb A* *Hb F 20-80%*	**Thalassemia major**	

β : normal gene

$β^{0}$: mutation **without** residual production of β-chains

$β^{+}$: mutation **with** residual production of β-chains

[1] Depending on residual β-globin chain synhesis

[2] Allogeneic hematopoietic stem cell transplantation

DIAGNOSIS

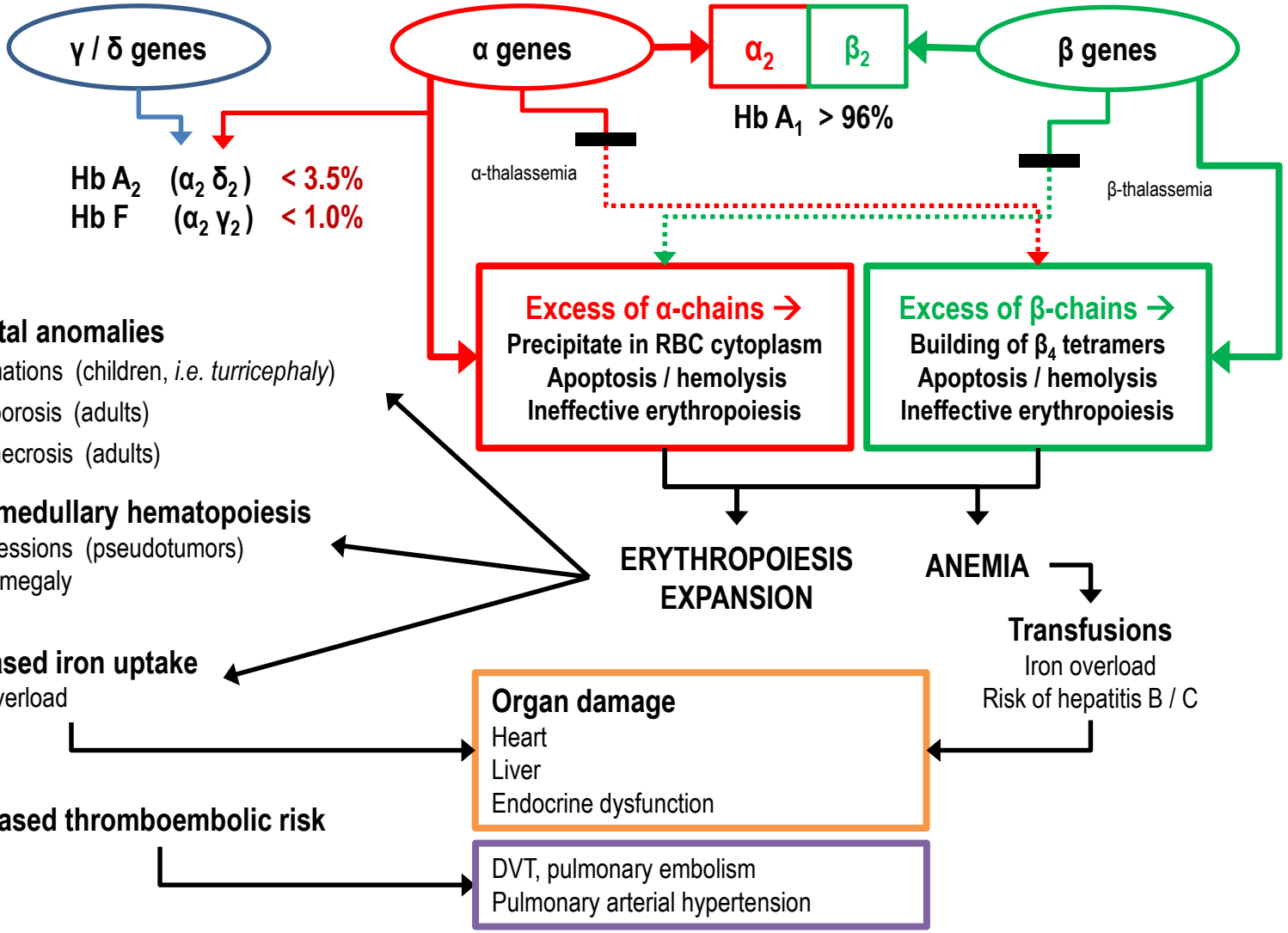
Hemoglobin electrophoresis

Isoelectric focusing

HPLC *(High Performance Liquid Chromatography)*

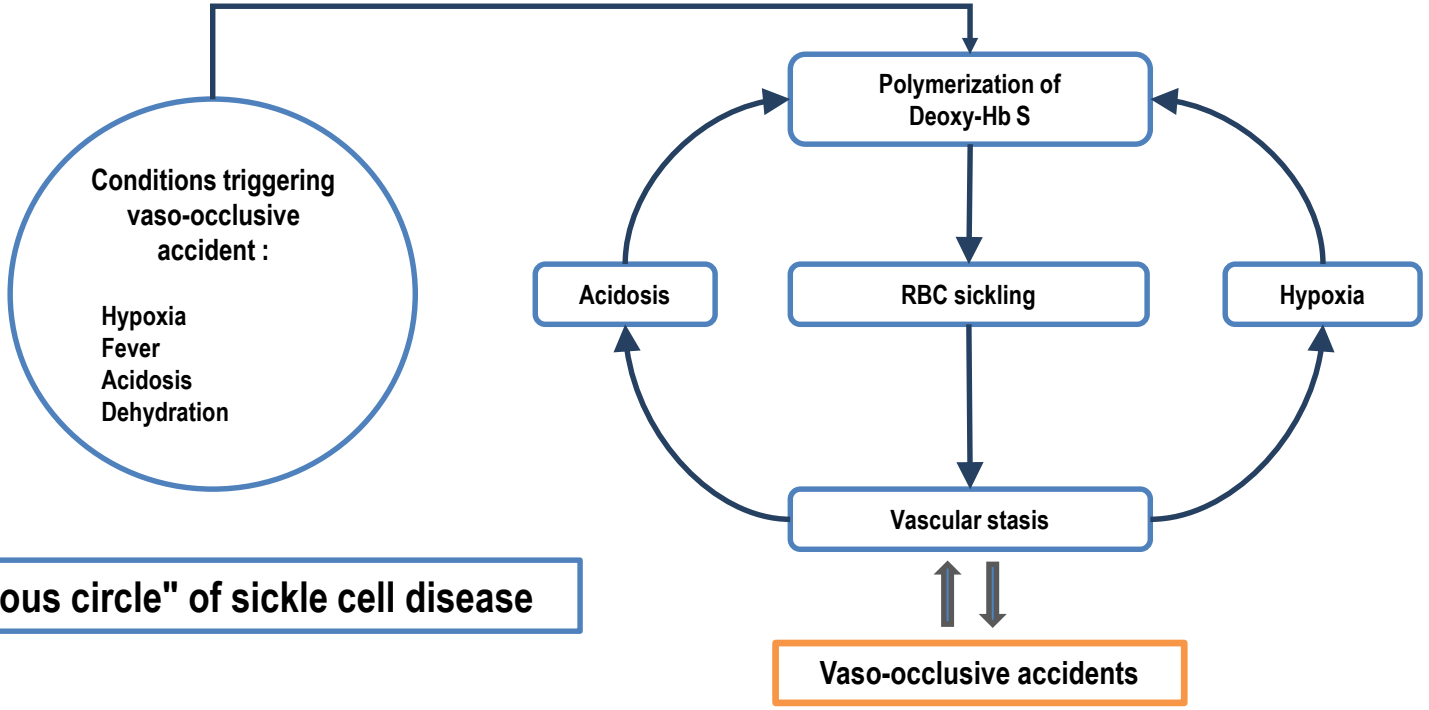
⚠ *Hb A_2 increase in thalassemia minor may be undetectable in case of associated iron deficiency which reduces its synthesis*

CLINICAL CONSEQUENCES OF THALASSEMIAS
THALASSEMIA MAJOR / INTERMEDIA



SICKLE CELL DISEASE
PATHOPHYSIOLOGY

Autosomal recessive transmission
Hemoglobin S : β6 Glu → Val
Polymerization in deoxygenated form : shape alteration of RBC to *drepanocytes* *("sickling")* with loss of plasticity



"Vicious circle" of sickle cell disease

Modified from Wajcman H., Lantz B., Girot R. : Les maladies du globule rouge 1992; Médecine-Sciences Flammarion : p. 184.

SICKLE CELL DISEASE (2)

Africa, Arabia, India, Mediterranean region, African Americans

CLINICAL FEATURES

HETEROZYGOUS VARIETY (A - S)

Approximately 30% of Hemoglobin S
Asymptomatic, occasionally kidneys may be affected with hyposthenuria, hematuria *(microinfarctions of medullary zone)*
Avoid severe hypoxemia *(apnea diving, general anesthesia)*
Protection against malaria

HOMOZYGOUS VARIETY (S - S)

Symptomatic since the age of 6 months : Hb F → Hb S
5 typical clinical manifestations :

1. **Vaso-occlusive crises**
2. **Splenic sequestration crises** *(children < 4 years)*
3. **Aplastic crises**
4. **Hemolytic crises**
5. **Infectious complications**

DIAGNOSIS

Hemoglobin electrophoresis
Screening by Emmel test or *in vitro RBC sickling test* *(sodium metabisulfite as reducing agent)*

TREATMENT

Rest / hydration / analgesia / exchange transfusion(s)
Hydroxyurea *(increased synthesis of Hb F)*

COMBINED GENETIC ANOMALIES OF HEMOGLOBIN

Combination of different genetic disorders of hemoglobin reflects the anomalies of the parents

Combination of a thalassemia with a hemoglobinopathy (Hb S, E, C)
Double heterozygosity for α- and β-thalassemia, etc.

Combined anomalies may have a favorable clinical impact compared to isolated disorder

SOME EXAMPLES :

GENOTYPE	HEMOGLOBIN LEVEL	MCV	MORPHOLOGY	HEMOGLOBINS	
HbS/S *(homozygous)*	60 – 100 g / L	Normal	Sickle cells 3-30%	HbS : > 75% HbA_1 : ∅	HbA_2 : 2 - 4% HbF : 2 - 20%
HbS / β^0-thalassemia	60 – 100 g / L	< 80 fL	Rare sickle cells Target cells	HbS : 60 - 90% HbA_1 : ∅	HbA_2 : 4 - 6% HbF : 1 - 15%
HbS / β^+- thalassemia	90 – 120 g / L	< 80 fL	Rare sickle cells Target cells	HbS : 55 - 75% HbA_1 : 3 - 30%	HbA_2 : 4 - 6% Hb-F : 1 - 15%
HbS / -α/αα-thalassemia	130 – 150 g / L	75 - 85 fL		HbS : 30 - 35%	
HbS / -α/-α-thalassemia	120 – 130 g / L	70 - 75 fL		HbS : 25 - 30%	
HbS / --/-α-thalassemia	70 – 100 g / L	50 - 55 fL		HbS : 17 - 25%	
HbS/S / -α/αα-thalassemia -α/-α-thalassemia	98 g / L 92 g / L	85 fL 72 fL		HbS : 80% HbS : 80%	
HbS/C	100 – 120 g / L	< 80 fL	Sickle cells, Hb C cristals Target cells	HbS : 50% / Hb C : 50% HbA_1 : ∅	HbA_2 : ∅ HbF : 2 - 10%

HEMOLYTIC ANEMIA DUE TO EXTRACORPUSCULAR DEFECT

IMMUNOLOGICAL

AUTOIMMUNE (AIHA)

Warm autoantibodies : IgG, IgA ± C3, C3 alone

- **Idiopathic AIHA (20%)**
- **Secondary AIHA (80%)**
  - **Lymphoid neoplasm (50%)**
  - **Infectious disease (30%)**
  - **Lupus erythematosus, other systemic autoimmune disease (15%)**
  - **Cancer (ovary, stomach), drugs, others (5%)**

Cold autoantibodies *(cold agglutinins)* **: IgM + C3**

- **Polyclonal** *(idiopathic, EBV, CMV, Mycoplasma pneumoniae)*
- **Monoclonal** *(lymphoid neoplasm, cold agglutinins disease)*

ALLOIMMUNE

Transfusion accident *(ABO or Rhesus incompatibility)*
Neonatal hemolytic anemia
Organ or bone marrow graft with ABO incompatibility

IMMUNOALLERGIC

Drugs *(penicillin and derivatives)*

TOXIC

INFECTIOUS

MECHANICAL

HYPERSPLENISM

All causes of splenomegaly, e.g. hepatic cirrhosis with portal hypertension. Presence of associated other cytopenias

HEMOPHAGOCYTOSIS

Viral, bacterial, fungal and parasitic infections in immunodeficient patients

TOXIC HEMOLYTIC ANEMIA
OXIDATIVE ORIGIN

PATHOPHYSIOLOGY

Hemoglobin oxidation to methemoglobin, then transformation to *hemichromes* which precipitate to form *Heinz bodies.* Oxidation of RBC membrane components

RESPONSIBLE SUBSTANCES

Industrial chemicals *(nitrites, chlorates, naphtalene, aniline derivatives)*
Drugs

MAIN DRUGS ABLE TO INDUCE OXYDATIVE HEMOLYTIC CRISIS	
ANTIMALARIALS	Pamaquine, pentaquine, primaquine, quinine
SULFONAMIDES	Sulfacetamide, sulfamethoxazole, sulfanilamide, sulfapyridine, sulfoxone, thiazosulfone, etc.
ANTIBIOTICS AND BACTERIOSTATIC AGENTS	Para-aminosalicylic acid, nalidixic acid, nitrofurantoin, chloramphenicol, etc.
ANTIPARASITIC DRUGS	Niridazole
ANALGESICS	Acetanilide, amidopyrine, paracetamol, phenacetin, etc.
OTHERS	Chloramine, formaldehyde, chlorates, nitrites, methylene blue, toluidine blue, naphtalene, phenylhydrazine, probenecid, trinitrotoluene

TOXIC HEMOLYTIC ANEMIA (2)
MULTIFACTORIAL ORIGIN

LEAD POISONING

ETIOLOGY	**Professional contact** *(welders, plumbers, lead containing paints, etc.)* **Use of lead containing dishes (ceramic), kitchenware** **Contaminated drinking water** *(old plumbing in ancient houses)*
PHYSIOPATHOLOGY	**Iron utilization disorder** **Reduced heme synthesis** *(inhibition of enzymes from porphyrin metabolism)* **Hemolysis** **Inhibition of pyrimidine-5'-nucleotidase, of activity of membrane pumps**
SYMPTOMS	**Acute abdominal pain** **Central and peripheral neurological signs** **Articular, renal, hepatic manifestations, arterial hypertension**
LABORATORY	**Normocytic or microcytic anemia, coarse basophil stippling of RBC** **Ring sideroblasts in highly variable number on bone marrow examination** **Increased level of erythrocytic protoporphyrin**
TREATMENT	**Suppression of lead exposure** **Chelation (i.e. DMSA : 2,3-dimercaptosuccinic acid)**

COPPER INTOXICATION

ETIOLOGY	**Plant health products** *(vine)* **Wilson disease (hemolysis may be the first manifestation)** **Contamination of dialysis fluids**
PHYSIOPATHOLOGY	**Enzymatic inhibition** *(particularly G-6-PD)*
SYMPTOMS	**Vomiting, abdominal pain** **Hepatic cytolysis, renal failure**

VENOMS

Spiders, snakes, scorpions

HEMOLYTIC ANEMIA OF INFECTIOUS ORIGIN

DIRECT ACTION ON RED BLOOD CELL

PARASITES

MALARIA

Plasmodium falciparum, vivax, malariae, ovale

Protection by : **Enzymopathy**
Hemoglobinopathy
Membrane anomaly
Blood group Duffy (-) : *Pl. vivax*

BABESIOSIS

BACTERIAS

CLOSTRIDIUM PERFRINGENS *(septic abortion)*

BARTONELLOSIS *(Oroya fever)*

OTHER PATHOPHYSIOLOGICAL MECHANISM

Immunological *(cold agglutinins due to Mycoplasma pneumoniae, EBV infection)*

Microangiopathic hemolysis *(HIV)*

HEMOLYTIC ANEMIA DUE TO MECHANIC RBC FRAGMENTATION (*SCHISTOCYTES*)

CARDIOVASCULAR DISORDERS

Valvular heart disease, operated or not
Anomalies of great blood vessels *(aortic coarctation)*
Extracorporeal circulation

MICROANGIOPATHY

THROMBOTIC THROMBOCYTOPENIC PURPURA (TTP[1]) *(Moschcowitz syndrome)*

ADAMTS 13 deficiency *(metalloproteinase cleaving high molecular weight von Willebrand factor multimers)*

Clinical features : *Fever*
Hemolytic anemia
Thrombocytopenia
Neurological symptoms
Renal failure

Treatment : *Plasma exchanges (3-4 L / 24 h)*

HEMOLYTIC UREMIC SYNDROME (HUS[2])

Sporadic form ***(D*⁻HUS)*** : ± *10% pediatric cases*

Epidemic form ***(D*⁺HUS)*** : *Verotoxin associated (Escherichia coli O157 : H7) : children ± 85%, adults ± 15%*

Clinical features : *Predominant renal failure*

Gastroenteritis with bloody diarrheas (D⁺ HUS)

Treatment : *Dialysis*

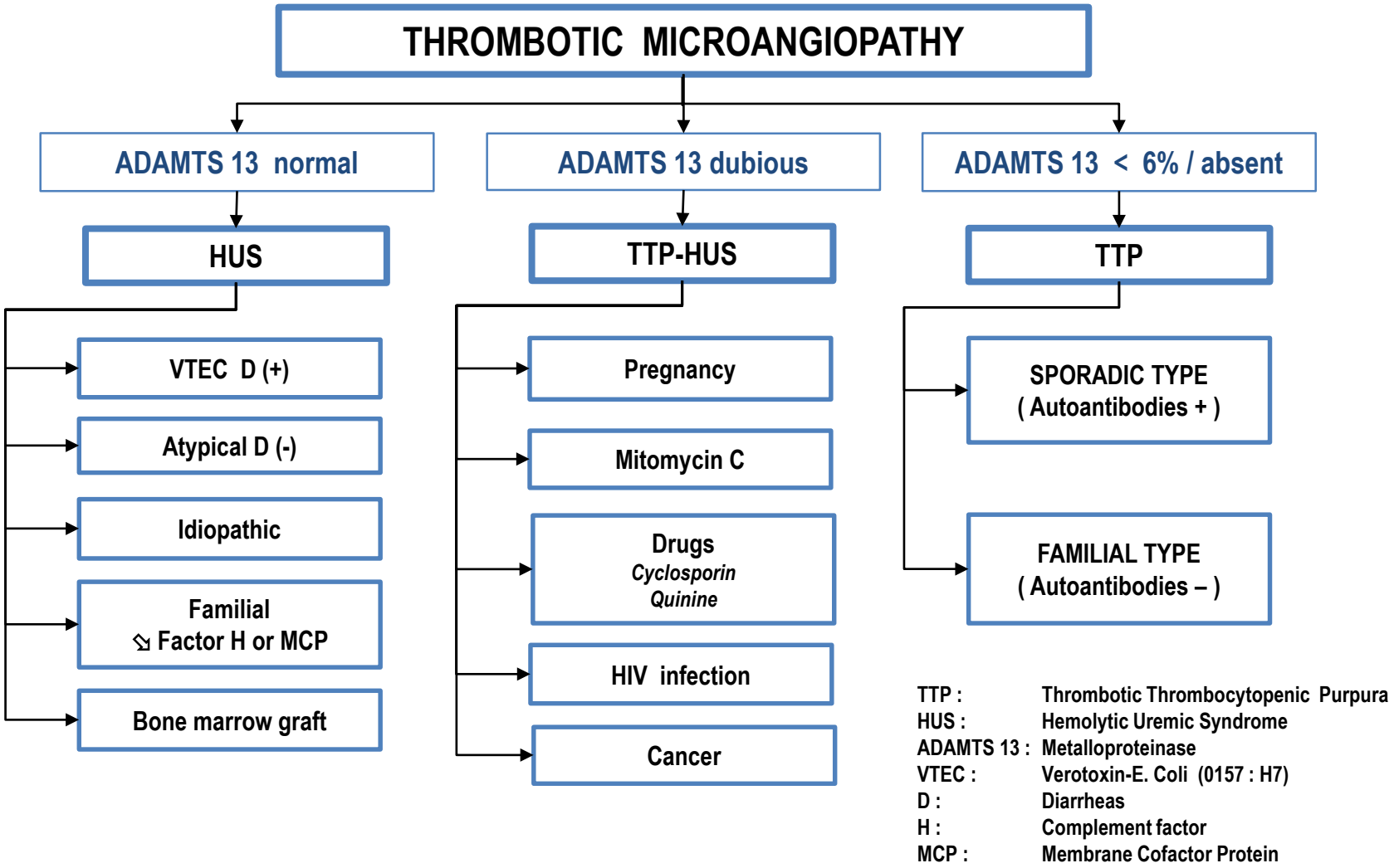
* ***Diarrheas***

DISSEMINATED INTRAVASCULAR COAGULATION

TRAUMATIC ORIGIN *(march hemoglobinuria)*

[1] TTP : Thrombotic Thrombocytopenic Purpura
[2] HUS : Hemolytic Uremic Syndrome

HEMOLYTIC ANEMIA DUE TO MECHANIC RBC FRAGMENTATION (2)
(*SCHISTOCYTES*)

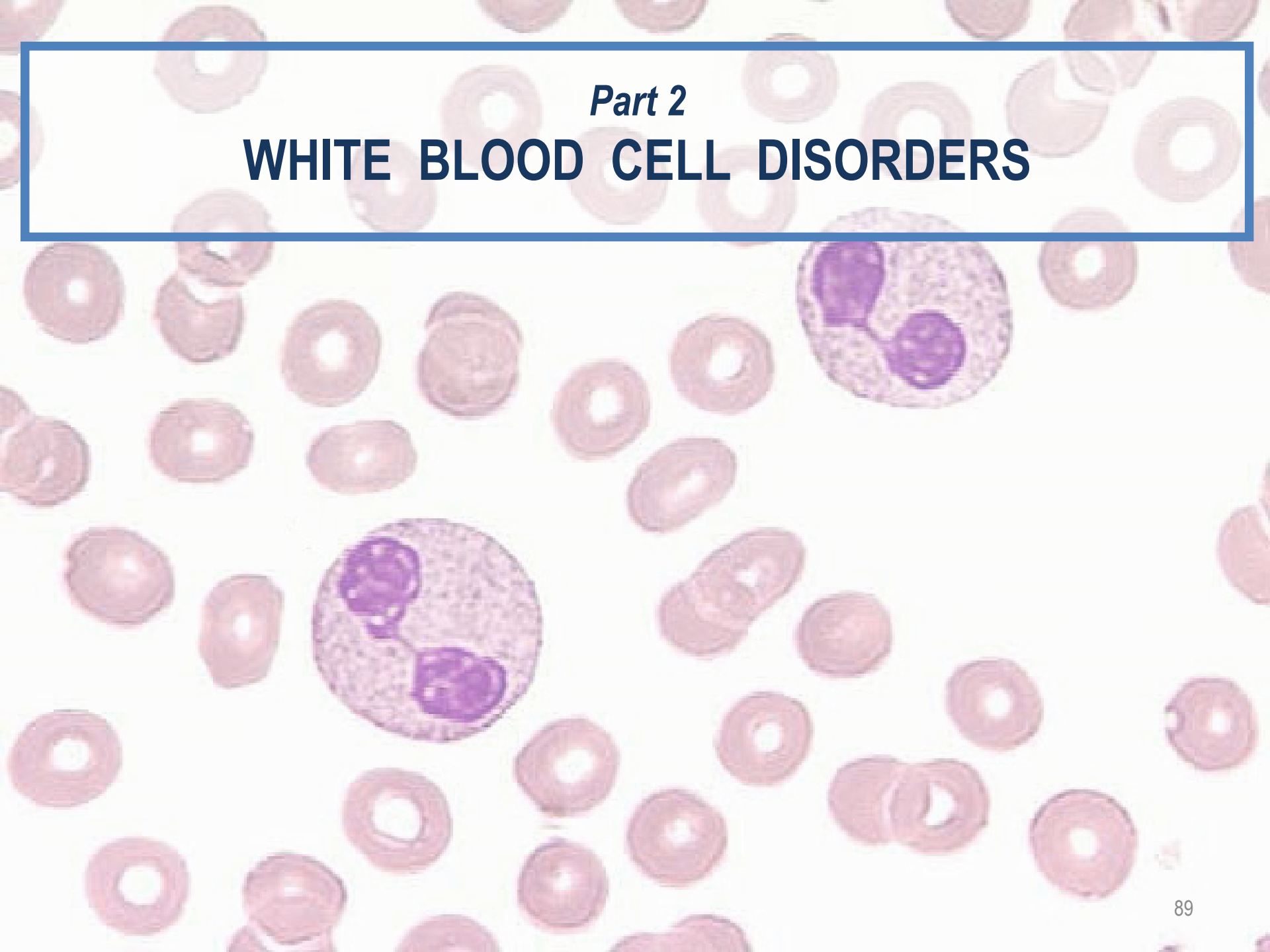


TTP :	Thrombotic Thrombocytopenic Purpura
HUS :	Hemolytic Uremic Syndrome
ADAMTS 13 :	Metalloproteinase
VTEC :	Verotoxin-E. Coli (0157 : H7)
D :	Diarrheas
H :	Complement factor
MCP :	Membrane Cofactor Protein

Modified from Liu J., J Thromb Thrombolysis 2001; 11 : 261-272, quoted in
Hoffman et al. : Hematology, Basic Principles and Practice 4th edition 2005; Elsevier : p. 2288.

Part 2

WHITE BLOOD CELL DISORDERS



DIFFERENTIAL LEUKOCYTE COUNT

LEUKOCYTES : 4.0 – 10.0 G / L		
	RELATIVE VALUES (%)	ABSOLUTE VALUES (G / L)
NEUTROPHILS	40 – 75	1.8 – 7.5
EOSINOPHILS	1 – 5	0.05 – 0.3
BASOPHILS	0 – 1	0.01 – 0.05
MONOCYTES	2 – 8	0.2 – 0.8
LYMPHOCYTES	25 – 40	1.5 – 4.0

LCH-CHUV, 2015

Left shift :

Band neutrophils *(non segmented neutrophils)*

> 1.0 G / L if leukocyte count > 4 G / L

> 25% if leukocyte count ≤ 4 G / L

Important to distinguish between relative and absolute counts :

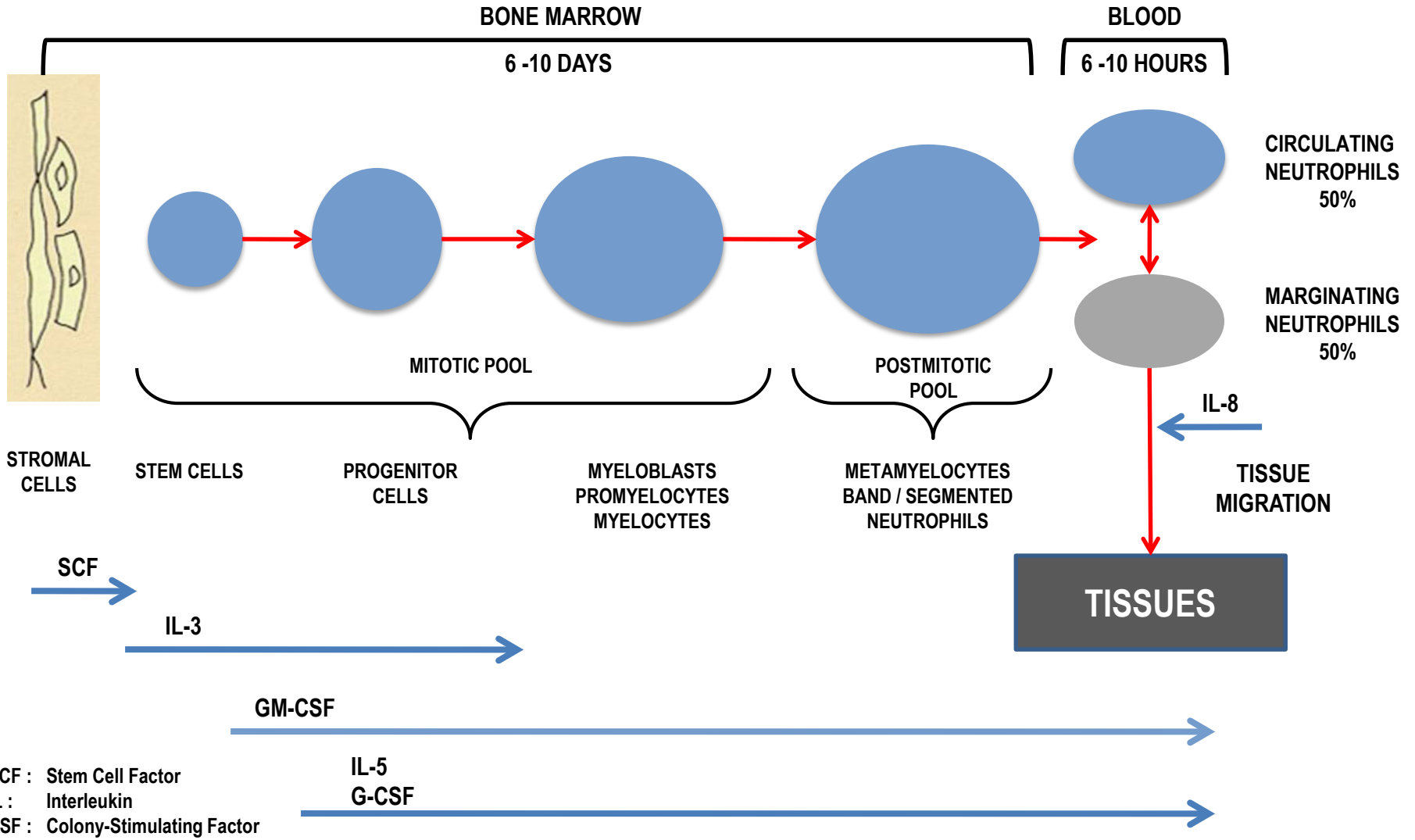
e.g. : chronic lymphocytic leukemia

Leukocyte count : 100 G / L
Neutrophils : 2%
Lymphocytes : 98%

→ ***Neutropenia relative but non absolute***

→ ***Lymphocytosis relative <u>and</u> absolute***

NEUTROPHIL GRANULOCYTES
KINETICS



SCF : Stem Cell Factor
IL : Interleukin
CSF : Colony-Stimulating Factor
G : Granulocyte
M : Monocyte

ETIOLOGY OF NEUTROPHILIC LEUKOCYTOSIS (NEUTROPHILIA)
(NEUTROPHIL COUNT > 7.5 G / L)

PHYSIOLOGICAL, USUALLY MODERATE

- **Neonate**
- **Violent exercise**
- **Menstruation**
- **Pregnancy**

PATHOLOGICAL

- **Inflammatory process**
  - **Bacterial infection localized** *(abscess)* **or generalized** *(septicemia)*
  - **Cancer**
  - **Inflammatory arthritis**
- **Tissue necrosis** *(myocardial infarction, pancreatitis, etc.)*
- **Regenerative phase of acute blood loss or hemolytic anemia**
- **Tobacco smoking, stress**
- **Drugs** *(steroids, G-CSF, GM-CSF, lithium)*
- **Myeloproliferative neoplasms**

TOXIC CHANGES OF NEUTROPHILS

Leukocytosis *(leukocyte count > 10.0 G / L)*

Neutrophilia *(neutrophil count > 7.5 G / L)*

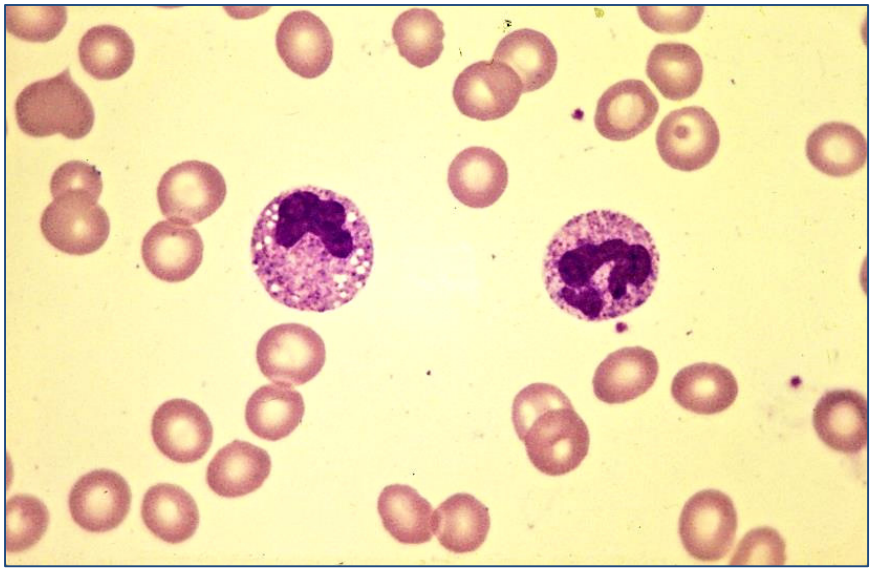
Neutrophil left shift : band neutrophil count > 1.0 G / L *(or > 25% if leukocyte count ≤ 4.0 G / L)*

Coarse granules of neutrophils, toxic granules

Doehle bodies *(basophilic cytoplasmic inclusions)*

Cytoplasmic vacuoles

Myelocytosis *(usually moderate)*



Toxic changes are seen in inflammatory process (acute or chronic bacterial infection, cancer, inflammatory arthritis) and tissue necrosis
Possible exceptions : neutropenia of salmonellosis, lymphocytosis of brucellosis and pertussis

MYELOCYTOSIS AND ERYTHROBLASTOSIS

DEFINITION

Presence in the peripheral blood of immature cells of neutrophilic lineage *(metamyelocytes, myelocytes, promyelocytes)* **with or without erythroblasts** *(rupture of marrow-blood barrier / extramedullar hematopoiesis)*

	Erythroblasts	Myelocytosis
Inflammatory process *(bacterial infection, cancer, etc.[1])*	–	+
Rupture of bone marrow-blood barrier *(skeletal cancer metastasis with bone marrow infiltration)*	+	+
Chronic myelogenous leukemia	– / +	+++
Primary myelofibrosis	+ (+)	+ (+)
Regeneration phase after acute blood loss or hemolysis	+ to +++	+
Recovery from agranulocytosis, G-CSF, GM-CSF	–	+ (+)

[1] **An important leukocytosis associated with toxic changes of neutrophils and myelocytosis is called leukemoid reaction**

NEUTROPENIA

DEFINITIONS

RELATIVE NEUTROPENIA : **< 40%**

ABSOLUTE NEUTROPENIA : **< 1.8 G / L**

AGRANULOCYTOSIS : **< 0.5 G / L** *(major risk of infection)*

CLASSIFICATION OF ABSOLUTE NEUTROPENIAS

PSEUDONEUTROPENIA

Excess neutrophil margination *(fasting patient, correction after meal)*

Splenic sequestration *("pooling")* **: Hypersplenism**

TRUE NEUTROPENIA

Reduced production and / or excessive destruction / demand

TRUE NEUTROPENIA
IMPAIRED PRODUCTION

QUANTITATIVE

- **Bone marrow aplasia**
- **Bone marrow infiltration**
- **Bone marrow fibrosis**
- **T-cell large granular lymphocytic leukemia (T-LGLL)**
- **Cyclic neutropenia**
- **Chronic ethnic or idiopathic neutropenia**

QUALITITIVE

- **Vitamin B_{12} and / or folate deficiency**
- **Myelodysplastic syndrome**

TRUE NEUTROPENIA (2)
REDUCED PRODUCTION AND / OR EXCESSIVE DESTRUCTION

INFECTIOUS NEUTROPENIA[1]

Viral *(influenza, hepatitis, varicella, measles, rubeola, EBV, HIV)*

Bacterial *(salmonellosis, brucellosis, sepsis with Gram negative germs)*

Parasitic *(malaria)*

IMMUNE NEUTROPENIA

Alloimmune *(neonatal neutropenia)*

Autoimmune *(disseminated lupus erythematosus, rheumatoid arthritis, drugs)*

Immunoallergic

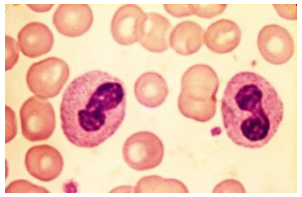
Drugs : **Mianserin** *(antidepressant)*, **sulfasalazine, phenylbutazone** *(anti-inflammatory agents)*, **cotrimoxazole** *(anti-infective)*, **metamizole** *(analgesic)*, **carbamazepine** *(anticonvulsant)*, ***carbimazole*** *(antithyroid drug)*

[1] **Immune pathogenic mechanism possible**

HEREDITARY MORPHOLOGICAL NEUTROPHIL ANOMALIES

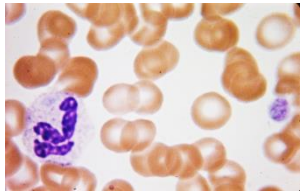
PELGER-HUET ANOMALY

Neutrophils with bilobate nucleus
(not to be mistaken for neutrophil left shift !)
Autosomal dominant anomaly[1]



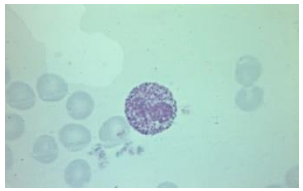
MAY-HEGGLIN ANOMALY

Basophilic cytoplasmic inclusions (RNA)[2]
Moderate thrombocytopenia with giant platelets
Autosomal dominant anomaly



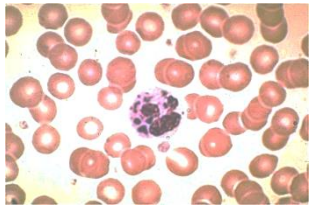
ALDER-REILLY ANOMALY

Coarse purple granules in neutrophils, monocytes and lymphocytes
Autosomal recessive anomaly



CHEDIAK-HIGASHI SYNDROME

Giant granules in neutrophils, eosinophils, monocytes and lymphocytes
Neutropenia *(infection)*
Thrombocytopenia *(hemorrhage)*
Hepatosplenomegaly
Autosomal recessive anomaly



[1] Acquired variety in myelodysplastic syndrome : "pelgeroid" nuclei = pseudo-Pelger
[2] Doehle bodies

EOSINOPHILS

FUNCTIONS

Positive chemotaxis for histamine *(secreted by mastocytes)*

Immune complex phagocytosis

Destruction of certain parasite larvae after prior antibody sensitization

EOSINOPHILIA (> 0.3 – 0.5 G / L)

Parasitosis *(helminths)*

Allergy *(allergic rhinitis, bronchial asthma)*

Drug *(penicillins, cephalosporins, analgesics, phenothiazines, anticonvulsants…)*

Systemic inflammatory disease *(polyarteritis nodosa)*

Cancer

Adrenal insufficiency

Hypereosinophilic syndrome

Myeloid and lymphoid neoplasms

- ***Acute myeloid leukemia with inv(16) or t(16;16)***
- ***Myeloid and lymphoid neoplasms with eosinophilia and anomalies of PDGFRA, PDGFRB or FGFR1***
- ***Chronic eosinophilic leukemia, NOS[1]***

[1] **Not Otherwise Specified**

BASOPHILS / MASTOCYTES

DEFINITION

Blood : **basophilic granulocytes**

Tissues : **tissue basophils or mastocytes**

FUNCTIONS

Surface receptors for IgE Fc fragment
"Bridging" effect of several IgE molecules by the specific allergen with degranulation and release of histamine *(bronchospasm in asthma bronchiale)***, heparin and a chemotactic factor for eosinophils**

BASOPHILIA (> 0.05 – 0.1 G / L)

Myeloproliferative neoplasm
Allergy
Hypothyroidism

MASTOCYTOSIS *(cf. p. 135)*

MONOCYTES / MACROPHAGES
FUNCTIONS

Chemotaxis, phagocytosis, killing

Antigen presentation to lymphocytes with help of HLA class I (T CD8 +) or class II (T CD4 +, B) molecules

Secretion

- **Hydrolases** *(acid phosphatase)*
- **Lysozyme**
- **Complement fractions**
- **Tumor Necrosis Factor** ***(TNF)***
- **Interleukin-1** ***(IL-1)***

Brain :	**Fever**
Liver :	**CRP**
Neutrophils :	**Activation**
T lymphocytes :	**GM-CSF, G-CSF, M-CSF, IL-2-7**
NK lymphocytes :	**Activation**
Endothelial cells :	**Proliferation, GM-CSF, M-CSF, IL-1, IL-5-7**

Activation by γ-Interferon, TNF and GM-CSF

CRP :	**C-Reactive Protein**
IL :	**Interleukin**
CSF :	**Colony-Stimulating Factor**
G :	**Granulocyte**
M :	**Monocyte**

MONOCYTES / MACROPHAGES (2)

ABSOLUTE MONOCYTOSIS (> 0.8 – 1.0 G / L)

REACTIVE

Infectious disease *(tuberculosis, bacterial endocarditis, salmonellosis, brucellosis, malaria)*

Recovery phase of bacterial infection

Recovery from agranulocytosis

Alcoholic hepatic disease

G-CSF or GM-CSF treatment

MALIGNANT

Chronic myelomonocytic leukemia

Acute myeloid leukemia with t(9;11), acute myelomonocytic leukemia, acute monocytic leukemia

MONOCYTOPENIA

Hairy cell leukemia

LYMPHOCYTES / LYMPHOID ORGANS

LYMPHOID ORGANS

Primary : **Bone marrow** *(lymphoid stem cells : CFU-L, B-cell differentiation and maturation)*

Thymus *(T-cell differentiation and maturation, thymic selection)*

Secondary : **Lymph node**

(B and T) **Spleen**

Digestive tract mucosa

Respiratory tract mucosa

PROPORTION OF B- AND T-LYMPHOCYTES IN BONE MARROW AND PERIPHERAL BLOOD

BONE MARROW	PERIPHERAL BLOOD
B ≥ T	T > B
CD8 > CD4	CD4 > CD8

B-LYMPHOCYTES

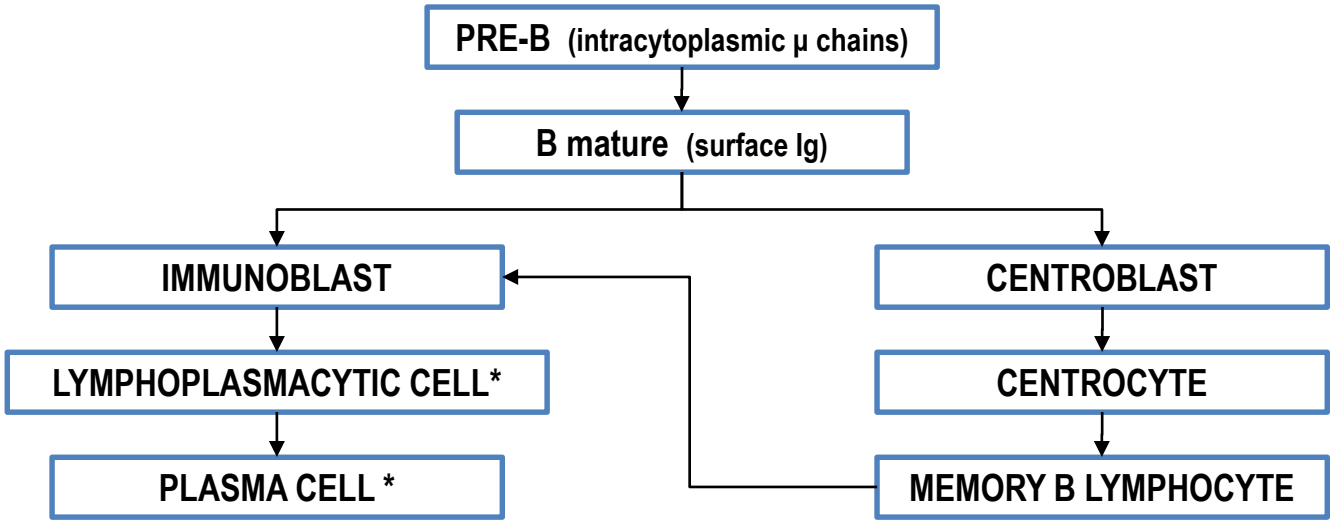
BONE MARROW

PRECURSORS :	**CFU-L CD34 +**
PRO-B :	**CD34 +, TdT +, HLA-DR +, CD19 +**
EARLY PRE-B :	**Rearrangement of immunoglobulins genes** *(heavy chains then light chains)*
	CD20 expression
PRE-B :	**Intracytoplasmic μ chains expression**
IMMATURE B :	**Surface IgM expression**

MIGRATION TO BLOOD AND SECONDARY LYMPHOID ORGANS

→ **MATURE B CELLS** *(surface IgM and IgD expression)*

STEPS OF B-LYMPHOCYTE MATURATION IN SECONDARY LYMPHOID ORGANS



* Plasmatic immunoglobulin (Ig) secretion

	IgG	IgA	IgM	IgD	IgE
Molecular weight (x 1'000)	140	160[1] (400[2])	900	170	190
Sedimentation constant	7 S	7 S[1] (11 S[2])	19 S	6.5 S	8 S
Placental transfer	Yes	No	No	No	No
Serum level (g / L)	8 – 12	1.4 – 4.0	0.5 – 1.9	0.03 – 0.4	0.0001
Half life (d)	21	7	5	2.8	2.3
Heavy chain	γ (1-4)	α (1-2)	μ	δ	ε
Light chain	κ or λ				

[1] Serum IgA
[2] Secretory IgA

Examples :

IgG $\gamma_2\kappa_2$ or $\gamma_2\lambda_2$

IgM $(\mu_2\kappa_2)_5$ or $(\mu_2\lambda_2)_5$ (pentamers)

T-LYMPHOCYTES / THYMIC SELECTION

MEDULLARY PRECURSORS (CFU-L) CD34 +

MIGRATION TO THYMUS

CORTICAL ZONE :

TCR expression (T-Cell Receptor), CD2, CD3

TCR gene rearrangement ($_{\gamma\delta}$ then $_{\alpha\beta}$)

***Positive selection*[1] : amplification of CD4 + CD8 + thymocytes with affinity for " self " class I and II molecules of the HLA system**

MEDULLARY ZONE :

***Negative selection*[1] : elimination of thymocytes with affinity for class I and II HLA molecules in contact with " self " antigens (clonal deletion)**

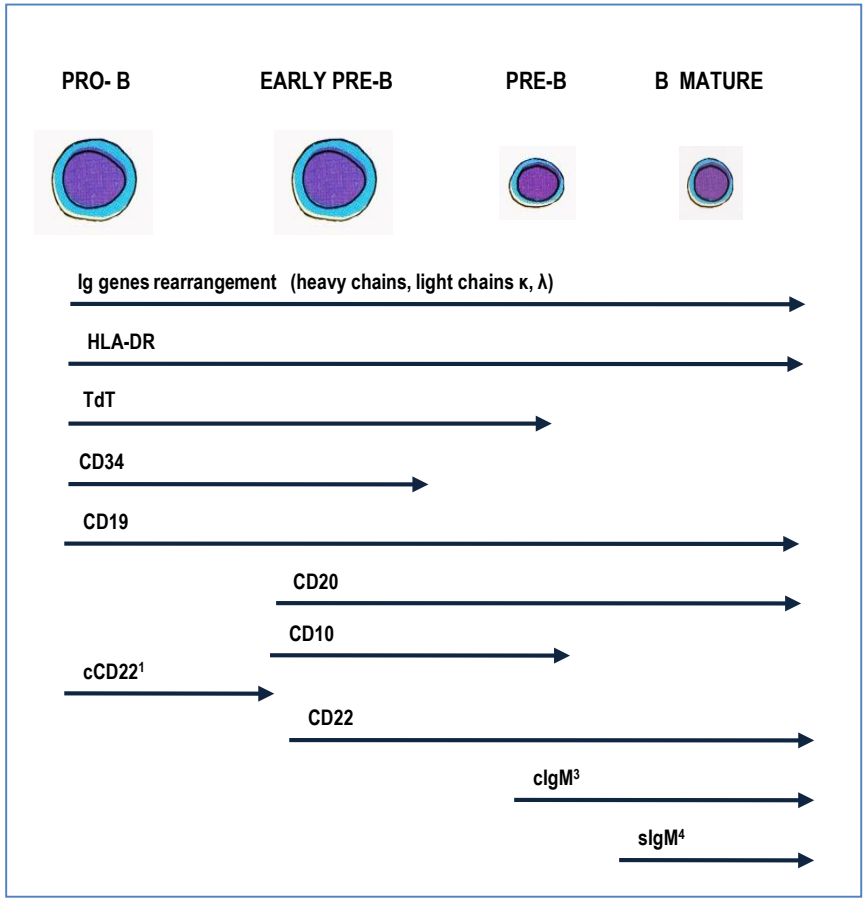
Expression of CD2, CD3, *CD4 + CD8 -* or *CD4 - CD8 +*

MIGRATION TO PERIPHERAL BLOOD AND SECONDARY LYMPHOID ORGANS

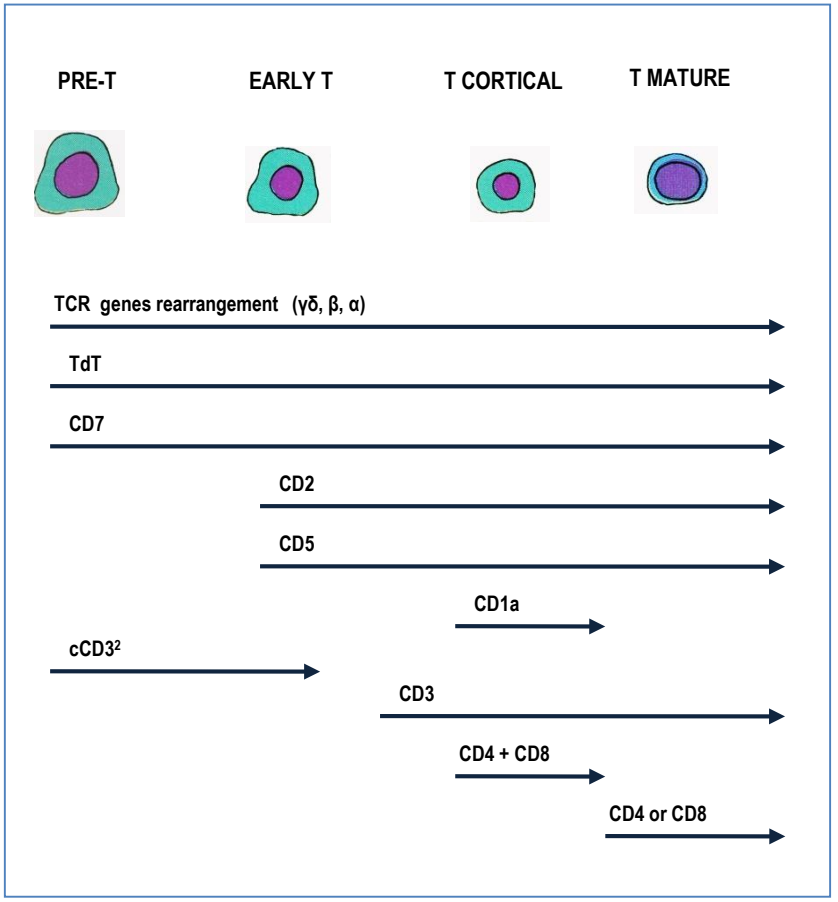
[1] During positive and negative selections approximately 90% of T-lymphocytes (thymocytes) are eliminated through apoptosis (cell death)

B- AND T-LYMPHOCYTE DIFFERENTIATION MARKERS

B-LYMPHOCYTE DIFFERENTIATION



T-LYMPHOCYTE DIFFERENTIATION



[1] cCD22 : intracytoplasmic CD22
[2] cCD3 : intracytoplasmic CD3
[3] cIgM : intracytoplasmic IgM
[4] sIgM : surface IgM

NK-LYMPHOCYTES (NATURAL KILLER LYMPHOCYTES)

Large granular lymphocytes (LGL variety)

CD3 -, CD2 +, CD8 + / -, CD16 +, CD56 +, CD57 + / -, absence of TCR

Cytotoxicity

1. **Inhibited by the presence of surface receptors for HLA class I molecules expressed by "self " cells**
   Stimulated by reduced synthesis *(or transport)* **of HLA class I molecules**
   (virus infected cells, tumor cells)

2. **CD16 + (Fc receptor) : binding of antibody to surface antigen → binding of a NK lymphocyte by the Fc, leading to activation**

LYMPHOCYTES / IMMUNE RESPONSE

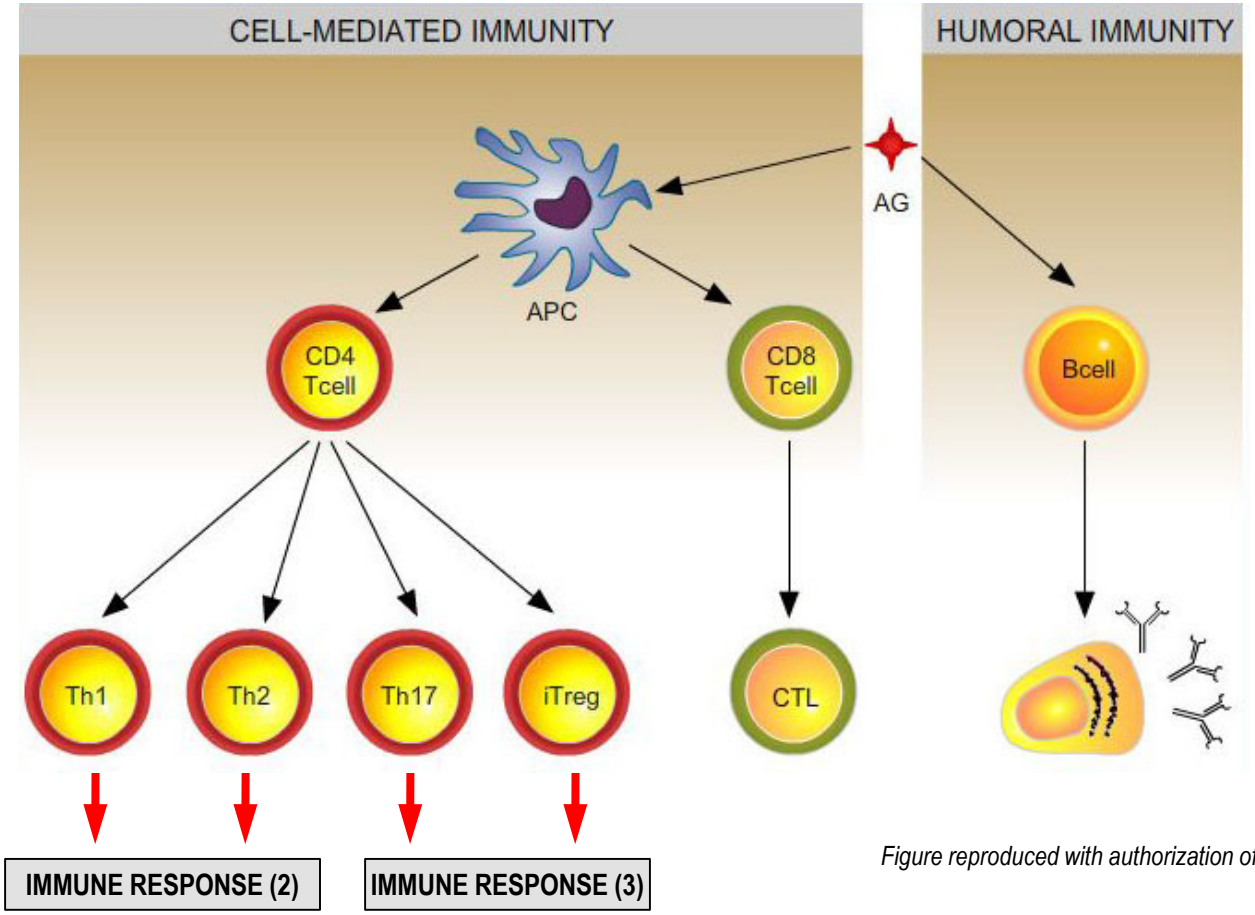
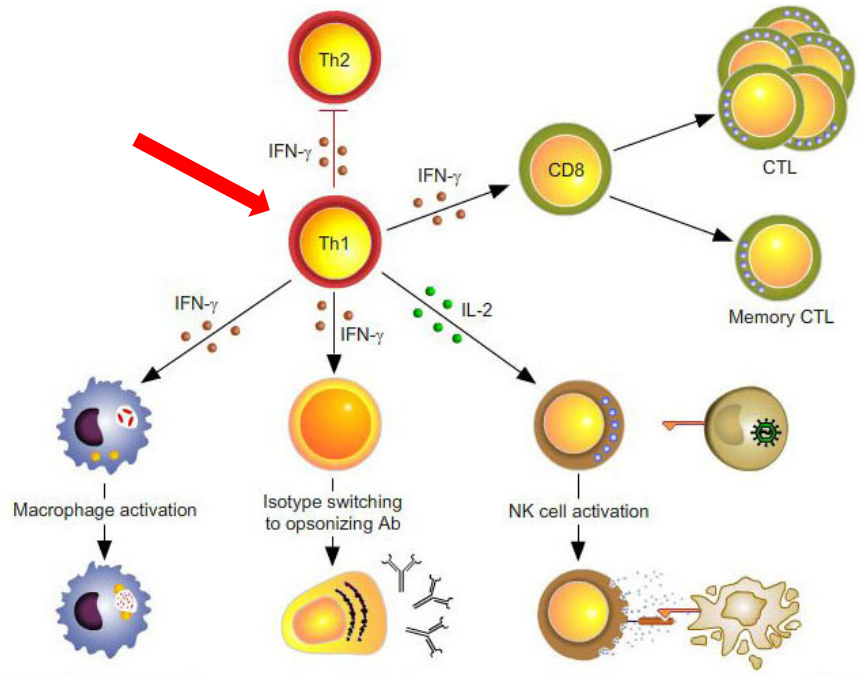


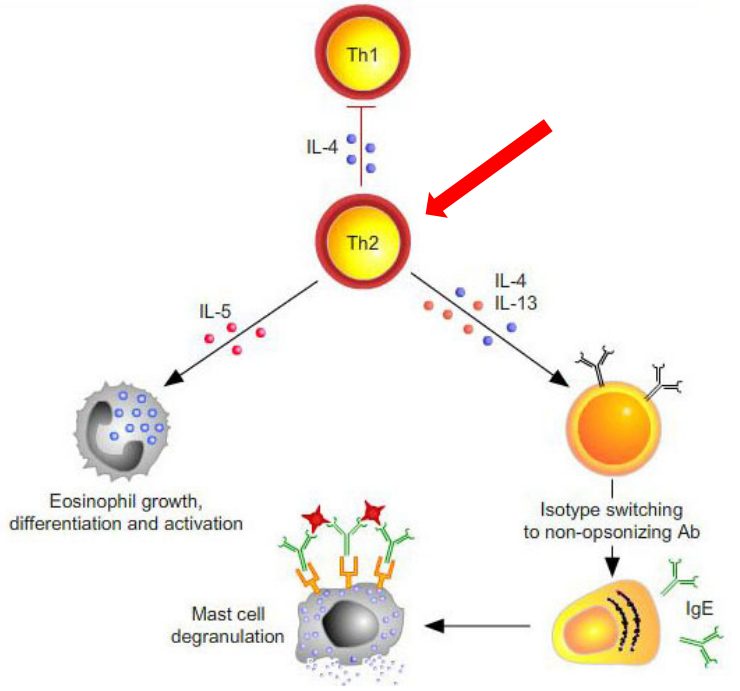
Figure reproduced with authorization of HSeT

Functionally, the adaptive immune system can be divided into two arms : **cell-mediated and humoral** immunity. B cells are responsible for the humoral response. B cells interact directly with antigen **(Ag)** and then differentiate into antibody-secreting cells. T cells are responsible for the cell-mediated immunity. They recognize antigens as short antigen fragments presented on the surface of antigen-presenting cells **(APC)**

T cells exist as two main functional groups : the **Helper T cells (Th)**, which respond to antigen by producing cytokines and the **cytotoxic T cells (CTL)** which respond to antigen by releasing cytotoxins. Depending on signals they receive from APC, the helper T cells can differentiate into four main subsets, with distinct profile of cytokines ***(Th1, Th2, Th17 and iTreg)***

LYMPHOCYTES / IMMUNE RESPONSE (2)





Th1 cells are required for defense against intracellular pathogens. They are characterized by the production of **IFN-γ** and **IL-2**. IFN-γ activates the microbicidal activity of macrophages, stimulates B cells to produce antibodies that are involved in the opsonization and phagocytosis of particulate microbes, and enhances the development of long-term memory **CD8 T** cells. IL-2 increases the cytolytic activity of natural killer cells ***(CTL NK)***

Th2 cells are required for defense against extracellular pathogens. They are characterized by the production of **IL-4**, **IL-5** and **IL-13**. IL-4 stimulates B cell proliferation and induces isotype class switch to **IgG1** and **IgE** and so plays a role in IgE-dependent mast cell-mediated reactions. IL-5 acts largely on eosinophils. IL-13 is homologous to IL-4 and induces many of the same functions, including inducing IgE isotype switching

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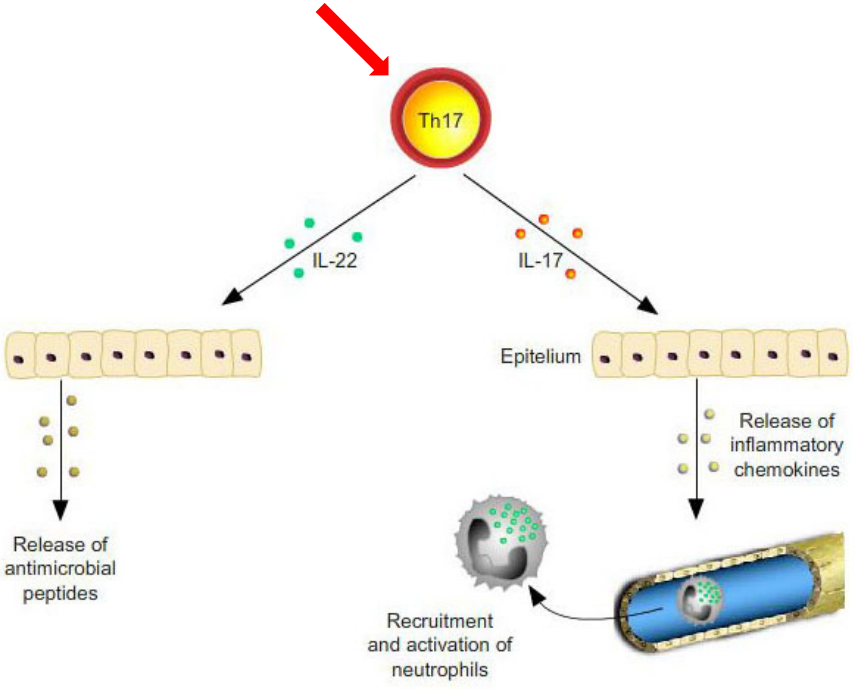
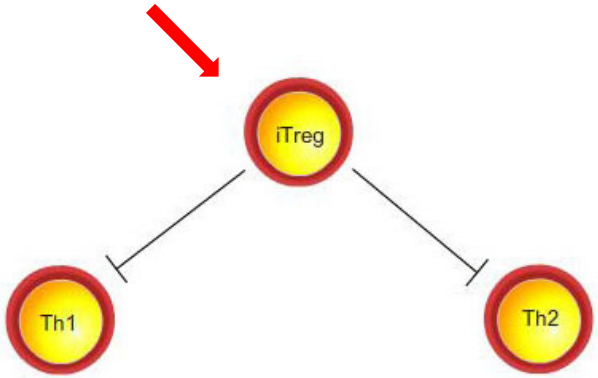
LYMPHOCYTES / IMMUNE RESPONSE (3)

LYMPHOCYTES Th 17



Th17 cells are the most recently discovered subset of Th cells and are thought to be important effector cells in host defense against extracellular bacteria and fungi. They are characterized by the production of **IL-17** and **IL-22**. IL-17 triggers the release of pro-inflammatory chemokines by epithelial cells, and various other tissues and cell types, helping thus the recruitment of neutrophils. IL-22 increases acute-phase reactants in hepatocytes and induces the expression of β-defensins in epithelial cells of the gastrointestinal tract and skin

LYMPHOCYTES iTreg



Induced **Treg cells** have functions in the suppression of Th1 and Th2 cell immune responses. Whether Treg cells also suppress Th17 cell responses is less clear

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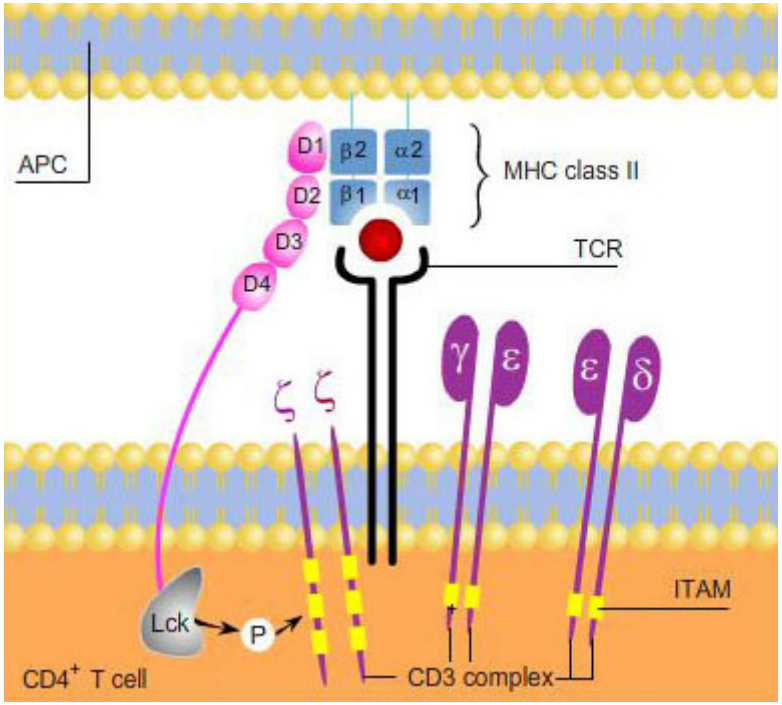
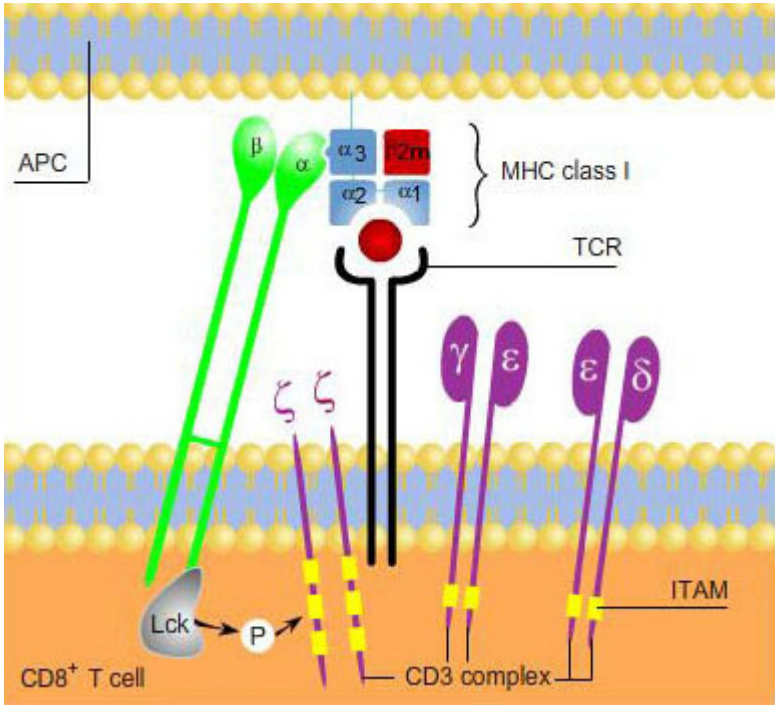
LYMPHOCYTES / IMMUNE RESPONSE (4)
CD 4 ET CD 8 CO-RECEPTORS OF T-LYMPHOCYTES





CD4 is a monomer that interacts via its two distal Ig domains (D1 and D2) with the β2 domain of MHC class II

CD8 is a dimer (either homodimer α or heterodimer αβ) that interacts via its α chain with the α3 domain of MHC class I

APC : Antigen Presenting Cell

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LYMPHOCYTOSIS / LYMPHOPENIA

LYMPHOCYTOSIS

RELATIVE : **> 40%**

ABSOLUTE : **> 4.0 G / L**

REACTIVE

- **Infection :** **viral**
  bacterial *(pertussis, tuberculosis, brucellosis, syphilis)*
- **Thyrotoxicosis**
- **Hyposplenism**

MALIGNANT

- **Lymphoid neoplasm**

ABSOLUTE LYMPHOPENIA : < 1.5 G / L

ACQUIRED

- **HIV, Hodgkin lymphoma, chemotherapy, radiotherapy, steroids**
- **ATG (Anti-thymocyte globulin), autoimmune disorder**

CONGENITAL

- **SCID (Severe Combined Immune Deficiency)**

IDIOPATHIC

PLASMACYTOSIS / MONONUCLEOSIS SYNDROME

PLASMACYTOSIS

REACTIVE : **Rubella** *(German measles)*

Other viral infection

MALIGNANT : **Plasma cell leukemia**

Plasma cell myeloma

MONONUCLEOSIS SYNDROME

Absolute lymphocytosis with polymorphic lymphocytes
(T-lymphocytes reactive to the infected B-lymphocytes)

Etiology : EBV[1] *(infectious mononucleosis)*

Lymphadenopathy	**100%**
Fatigue	**90%**
Pharyngitis syndrome	**80%**
Splenomegaly	**> 50%**

Possibly hemolytic anemia and / or autoimmune thrombocytopenia, agranulocytosis, cardiac / neurological / respiratory complications, splenic rupture

CMV *(cytomegalovirus infection, frequently promoted by immunosuppression)*

HIV *(primary infection)*

Other virus *(e.g. hepatitis)*

Toxoplasmosis

[1] **Also involved in the pathogenesis of certain lymphoid neoplasms (African Burkitt, Hodgkin lymphoma, lymphoid neoplasms + HIV)**

TUMORS OF HEMATOPOIETIC AND LYMPHOID TISSUES
WHO CLASSIFICATION 2008

MYELOID NEOPLASMS *(cf. p. 118-160)*

LYMPHOID NEOPLASMS *(cf. p. 161-203)*

B-CELL NEOPLASMS

PRECURSOR B-CELL NEOPLASMS

B-lymphoblastic leukemia / lymphoma

MATURE B-CELL NEOPLASMS

Chronic lymphocytic leukemia / small lymphocytic lymphoma
B-cell prolymphocytic leukemia
Splenic B-cell marginal zone lymphoma
Hairy cell leukemia
Splenic B-cell lymphoma / leukemia, unclassifiable
Splenic diffuse red pulp small B-cell lymphoma
Hairy cell leukemia-variant
Lymphoplasmacytic lymphoma
Waldenström Macroglobulinemia
Heavy chain diseases
Plasma cell neoplasms
Extranodal marginal zone lymphoma of Mucosa-Associated Lymphoid Tissues (MALT lymphoma)
Nodal marginal zone lymphoma
Follicular lymphoma
Primary cutaneous follicle centre lymphoma
Mantle cell lymphoma

Diffuse large B-cell lymphoma (DLBCL[1]), NOS[2]
T-cell / histiocyte rich DLBCL
Primary DLBCL of the CNS
Primary cutaneous DLBCL, leg type
EBV positive DLBCL of the elderly
DLBCL associated with chronic inflammation
Lymphomatoid granulomatosis
Primary mediastinal (thymic) large B-cell lymphoma
Intravascular large B-cell lymphoma
ALK[3] positive large B-cell lymphoma
Plasmablastic lymphoma
Large B-cell lymphoma arising in HHV8-associated multicentric Castleman disease
Primary effusion lymphoma
Burkitt lymphoma
B-cell lymphoma, unclassifiable, with features intermediate between DLBCL and Burkitt lymphoma
B-cell lymphoma, unclassifiable, with features intermediate between DLBCL and Hodgkin lymphoma

[1] DLBCL : Diffuse large B-Cell Lymphoma
[2] NOS : Not Otherwise Specified
[3] ALK : Anaplastic Lymphoma Kinase

Swerdlow S.H., Campo E., Harris N.L., Jaffe E.S., Pileri S.A., Stein H., Thiele J., Vardiman J.W. : WHO Classification of Tumours of Haematopoietic and Lymphoid Tissues, 4th ed. 2008; IARC, Lyon.

TUMORS OF HEMATOPOIETIC AND LYMPHOID TISSUES
WHO CLASSIFICATION 2008 (2)

T-CELL AND NK-CELL NEOPLASMS

PRECURSORS T-CELL NEOPLASMS
T-cell lymphoblastic lymphoma / leukemia

MATURE T-CELL AND NK-CELL NEOPLASMS
T-cell prolymphocytic leukemia
T-cell large granular lymphocytic leukemia
Chronic lymphoproliferative disorders of NK-cells
Aggressive NK-cell leukemia
Systemic EBV-positive T-cell lymphoproliferative disorders of childhood
Hydroa vacciniforme-like lymphoma
Adult T-cell leukemia / lymphoma
Extranodal NK / T-cell lymphoma, nasal type
Enteropathy-associated T-cell lymphoma
Hepatosplenic T-cell lymphoma
Subcutaneous panniculitis-like T-cell lymphoma
Mycosis fungoides
Sézary syndrome
Primary cutaneous CD30 positive T-cell lymphoproliferative disorders
Primary cutaneous gamma-delta T-cell lymphoma
Peripheral T-cell lymphoma not otherwise specified
Angioimmunoblastic T-cell lymphoma
Anaplastic large cell lymphoma (ALCL), ALK[1] positive
Anaplastic large cell lymphoma (ALCL), ALK[1] negative

[1]ALK : Anaplastic Lymphoma Kinase

HODGKIN LYMPHOMA (HODGKIN DISEASE) *(cf. p. 200-203)*

Swerdlow S.H., Campo E., Harris N.L., Jaffe E.S., Pileri S.A., Stein H., Thiele J., Vardiman J.W. : WHO Classification of Tumours of Haematopoietic and Lymphoid Tissues, 4th ed. 2008; IARC, Lyon.

TUMORS OF HEMATOPOIETIC AND LYMPHOID TISSUES
WHO CLASSIFICATION 2008 (3)

IMMUNODEFICIENCY-ASSOCIATED LYMPHOPROLIFERATIVE DISORDERS

Lymphoproliferative diseases associated with primary immune disorders
Lymphomas associated with HIV infection
Post-Transplant Lymphoproliferative Disorders (PTLD)
- Early lesions
  - Plasmacytic hyperplasia
  - Infectious mononucleosis-like PTLD
- Polymorphic PTLD
- Monomorphic PTLD (criteria for one of the B-cell or T / NK-cell neoplasms of immunocompetent host)
- Classical Hodgkin lymphoma-type PTLD

Other iatrogenic immunodeficiency-associated lymphoproliferative disorders

HISTIOCYTIC AND DENDRITIC CELL NEOPLASMS

Histiocytic sarcoma
Langerhans cell histiocytosis
Langerhans cell sarcoma
Interdigitating dendritic cell sarcoma
Follicular dendritic cell sarcoma
Fibroblastic reticular cell tumor
Indeterminate dendritic cell tumor
Disseminated juvenile xanthogranuloma

Swerdlow S.H., Campo E., Harris N.L., Jaffe E.S., Pileri S.A., Stein H., Thiele J., Vardiman J.W. : WHO Classification of Tumours of Haematopoietic and Lymphoid Tissues, 4th ed. 2008; IARC, Lyon.

MYELOID NEOPLASMS

MYELOPROLIFERATIVE NEOPLASMS (MPN)

MYELOID AND LYMPHOID NEOPLASMS WITH EOSINOPHILIA AND ANOMALIES OF *PDGFRA*, *PDGFRB* OR *FGFR1*

MYELODYSPLASTIC SYNDROMES (MDS)

MYELODYSPLASTIC / MYELOPROLIFERATIVE NEOPLASMS (MDS / MPN)

ACUTE MYELOID LEUKEMIAS (AML) AND RELATED PRECURSOR NEOPLASMS

ACUTE LEUKEMIAS OF AMBIGUOUS LINEAGE

STEM CELL PROLIFERATION AND DIFFERENTIATION IN MYELOID NEOPLASMS

	STEM CELL Genetic mutation Humoral factors Cellular interactions	
	PROLIFERATION	DIFFERENTIATION
Myeloproliferative neoplasms	+	+
Myelodysplastic syndromes Myelodysplastic / myeloproliferative neoplasms	±	±
Acute myeloid leukemias (AML) and related precursor neoplasms Acute leukemias of ambiguous lineage	+	–

MYELOPROLIFERATIVE NEOPLASMS

GENERAL FEATURES

Stem cell somatic mutation upstream from the myeloid precursor cell
Proliferation and maturation
Increase in peripheral blood of cells arising from one or more lineages
Myeloid metaplasia *(extramedullary hematopoiesis)*
Frequent bone marrow fibrosis
Platelet function disorders
Hyperuricemia
Possible transformation in acute leukemia

WHO CLASSIFICATION 2008

Polycythemia Vera (PV)
Chronic myelogenous leukemia (CML) ***BCR-ABL 1*** **+**
Essential thrombocythemia (ET)
Primary myelofibrosis (PMF)
Chronic neutrophilic leukemia (CNL)
Chronic eosinophilic leukemia (CEL), NOS[1]
Mastocytosis *(cf. p. 135)*
Myeloproliferative neoplasm, unclassifiable

[1] NOS : Not Otherwise Specified

POLYCYTHEMIA VERA (PV)

SYMPTOMS AND CLINICAL SIGNS

Facial erythrocyanosis
Water pruritus
Epigastralgia
Hyperviscosity *(thromboembolic manifestations, headache, dizziness, paresthesias)*
Splenomegaly

DIAGNOSTIC CRITERIA

MAJOR	**A1**	**Hb > 185 g / L (men), > 165 g / L (women) or increased isotopic RBC mass > 25% of predicted value**
	A2	**Presence of *JAK2* V617F[2] or other functionally similar mutation such as *JAK2* exon 12 mutation[3]**
MINOR	**B1**	**Bone marrow biopsy showing hypercellularity for age with trilineage growth with prominent erythroid, granulocytic and megakaryocytic hyperplasia**
	B2	**Endogenous erythropoietin serum level below the reference range for normal**
	B3	**Spontaneous erythroid colony growth *in vitro* without EPO**

PV established if :

A1 + A2 + 1 minor criterion
or :
A1 + 2 minor criteria

[2] *JAK2* V617F exon 14 : 95-97%
[3] *JAK2* exon 12 : about 3%

Tefferi A. : Clinical manifestations and diagnosis of polycythemia vera; December 2014, UpToDate.

POLYCYTHEMIA VERA (2)

COMPLICATIONS

Thromboembolic

Hemorrhagic

Evolution to myelofibrosis, ~10% *(post-polycythemic phase)*, *(cf. p. 130)*

Transformation in myelodysplastic syndrome or acute leukemia *(> 10% after treatment with cytotoxic drugs)*

PROGNOSIS

Median survival : > 10 years

TREATMENT *(Targets : hematocrit < 45%; platelets < 450 G / L)*

Phlebotomies

Hydroxyurea, α-Interferon, pegylated α-Interferon

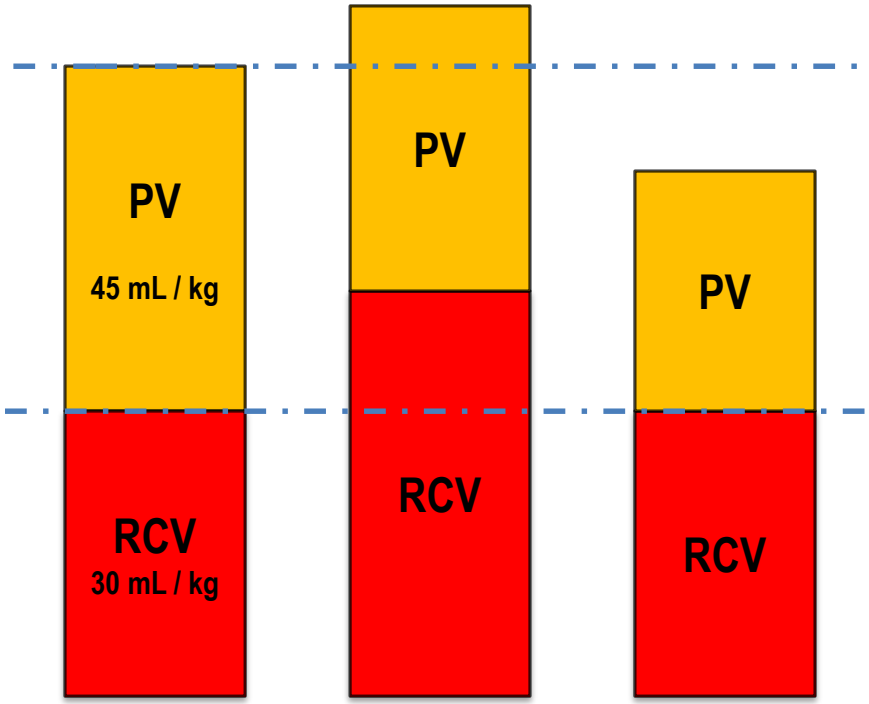
Aspirin

JAK1 / JAK2 specific tyrosine kinase inhibitors (Ruxolitinib) : if failure of Hydroxyurea or intolerance to the drug

^{32}P: obsolete treatment, possibly restricted to patients with life expectancy < 10 years and bad compliance to other treatment if available *(increased risk of leukemic transformation).*

DIFFERENTIAL DIAGNOSIS OF ERYTHROCYTOSIS

RBC VOLUME AND PLASMA VOLUME



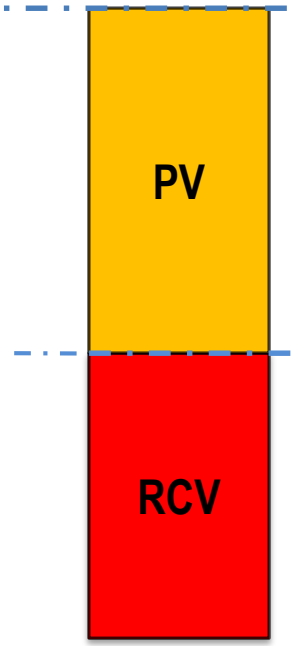
NORMAL

TRUE ERYTHROCYTOSIS

RELATIVE ERYTHROCYTOSIS

Dehydration
Contraction of plasma volume
Gaisböck syndrome *(stress pseudoerythrocytosis)*

- Male prevalence
- Sedentary way of life
- Light obesity
- Tobacco smoking
- Hyperlipidemia
- Hyperproteinemia
- Thromboembolic risk



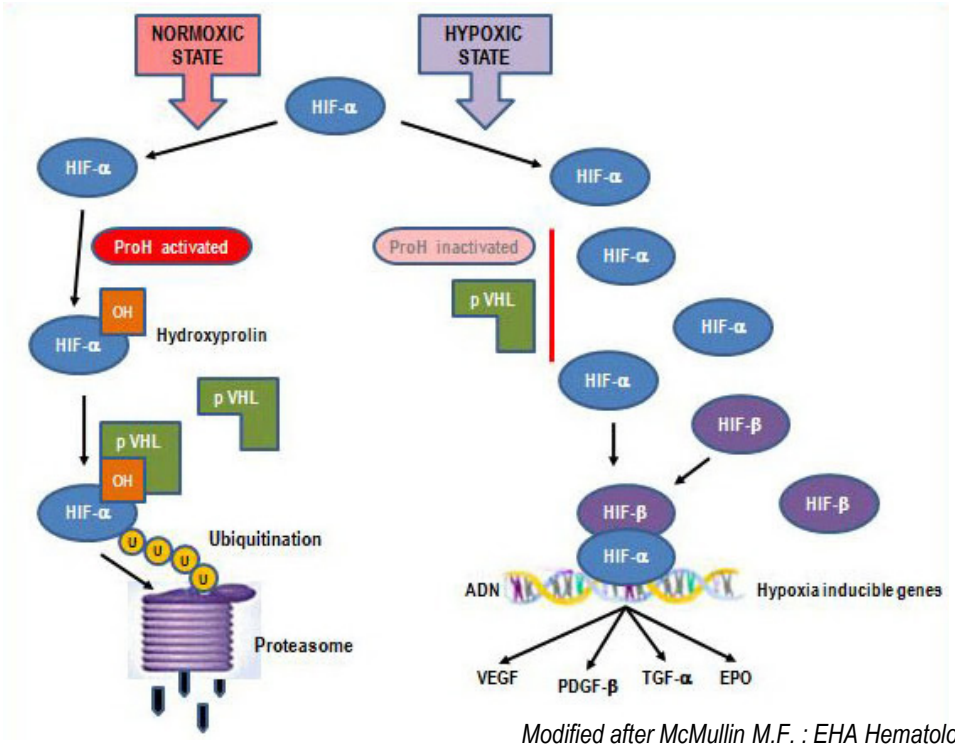
MICRO-ERYTHROCYTOSIS

Thalassemia minor

PV : PLASMA VOLUME
RCV : RED CELL VOLUME

DIFFERENTIAL DIAGNOSIS OF TRUE ERYTHROCYTOSIS

PRIMARY ERYTHROCYTOSIS	**Congenital**	**EPO receptor mutation**	**EPO ⇘**
	Acquired	**Anomaly of erythroid precursors *(Polycythemia Vera)***	
SECONDARY ERYTHROCYTOSIS	**Congenital**	**Absence of erythroid precursors anomaly Mutations impairing the system of tissue oxygenation sensing High O_2-affinity hemoglobins**	**EPO ⇗ or normal**
	Acquired	**Appropriate or abnormal EPO secretion**	



SENSING PROCESS OF TISSULAR OXYGENATION

In state of normal oxygenation HIF-α protein is rapidely degraded by the action of prolin-hydroxylase and von Hippel-Lindau protein, followed by ubiquitination and destruction in the proteasome

In hypoxic state HIF-α degradation is blocked. The protein is activated by dimerization with HIF-β. The complex acts as a promoter of various genes involved in synthesis of growth factors like EPO

HIF : Hypoxia Inducible Factor
pVHL : von Hippel-Lindau protein
ProH : Prolin-Hydroxylase
U : Ubiquitin
VEGF : Vascular Endothelial Growth Factor
PDGF : Platelet-Derived Growth Factor
TGF : Tissue Growth Factor

Modified after McMullin M.F. : EHA Hematology Education, 2009; 3 : 238-241.

DIFFERENTIAL DIAGNOSIS OF TRUE ERYTHROCYTOSIS (2)

PRIMARY ERYTHROCYTOSIS

CONGENITAL

Mutation of EPO[1] receptor

ACQUIRED

Polycythemia Vera

SECONDARY ERYTHROCYTOSIS

CONGENITAL

Mutation of VHL[2] gene *(Chuvash erythrocytosis)*
Mutation of PHD2[3]
Mutation of HIF-2-α[4]
O_2 high-affinity hemoglobins
2,3-diphosphoglyceromutase deficiency

ACQUIRED

Appropriate EPO[1] production

Central hypoxia

Chronic pulmonary disorder, cardio-pulmonary right-left shunt, CO intoxication, chronic smoking, hypoventilation syndromes incl. sleep apnea, prolonged stay at high altitude

Local renal hypoxia

Renal artery stenosis, terminal renal failure, hydronephrosis, polycystic kidneys, post renal transplantation erythrocytosis

Abnormal EPO[1] production

Tumors : *cerebellar hemangioblastoma, meningioma, parathyoid carcinoma / adenoma, hepatocellular carcinoma, renal cell carcinoma, pheochromocytoma, uterine leiomyoma*

Drugs : *androgens*

Exogenous EPO[1] application

Therapeutical indication
Illegal application *(doping !)*

IDIOPATHIC ERYTHROCYTOSIS

[1] ***EPO :*** ***Erythropoietin***
[2] ***VHL :*** ***Von Hippel-Lindau (recessive mutations)***
[3] ***PHD2 :*** ***Prolyl-Hydroxylase Domain (dominant mutations)***
[4] ***HIF :*** ***Hypoxia Inducible Factor (dominant mutations)***

Modified after McMullin M.F. : EHA Hematology Education, 2009; 3 : 238-241.

CHRONIC MYELOGENOUS LEUKEMIA (CML)

SYMPTOMS AND CLINICAL FEATURES

Fortuitous diagnosis - asymptomatic patient
Digestive symptoms *(abdominal heaviness, bloating)*
Splenomegaly
Thrombosis
Hemorrhage
Leucostasis *(CML with very high leukocyte count)*

BLOOD PICTURE

Leukocytosis with neutrophilia
Neutrophil left shift, myelocytosis (20-50%), basophilia
Frequent thrombocytosis
Low leukocyte alkaline phosphatase score *(obsolete test)*

PROGNOSTIC SCORES

The Sokal prognostic score[1], based on age, spleen size, percentage of blasts in peripheral blood and platelet count ist still favored by clinicians even if the EUTOS score[2] seems more accurate since treatment with tyrosine kinase inhibitors instead of chemotherapy

CYTOGENETICS

Philadelphia chromosome (Ph) = t(9;22)(q34;q11.2) : translocation between long arms of chromosome 9 and chromosome 22 : 90-95% of cases, t(9;22) variants : 5-10%

MOLECULAR BIOLOGY

BCR-ABL 1 rearrangement : 100% of cases

[1] See : www.leukemia-net.org/content/leukemias/cml/cml_score
[2] See : www.leukemia-net.org/content/leukemias/cml/eutos_score

[2] *Hasford J. et al.. : Predicting complete cytogenetic response and subsequent progression-free survival in 2060 patients with CML on imatinib treatment : The EUTOS score. Blood 2011; 118 (3) : 686-692.*

CHRONIC MYELOGENOUS LEUKEMIA (2)

COURSE IN 3 PHASES

CHRONIC

ACCELERATION[1]

Blasts **10-19%** *(blood and / or nucleated bone marrow cells)*

Basophils **≥ 20%** *(blood)*

Thrombopenia **< 100 G / L** *(treatment independent)*

Clonal genetic evolution

Thrombocytosis **> 1'000 G / L** *(unresponsive to treatment)*

Increasing splenomegaly and leukocytosis *(unresponsive to treatment)*

TRANSFORMATION

Blasts : **≥ 20%** *(blood and / or nucleated bone marrow cells)*

Extramedullary blast cell proliferation

[1]*Modified from Vardiman J.W., Harris N.L., Brunning R.D.: The World Health Organization (WHO) classification of the myeloid neoplasms. Blood 2002; 100 : 2292-2302.*

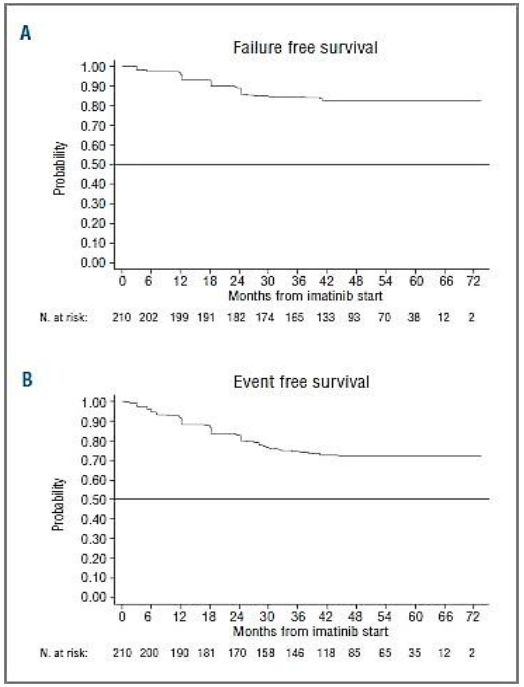
PROGNOSIS

Depends on :

Clinical stage

Prognostic factors

Response to tyrosine kinase inhibitors



Actuarial curves of relapse free survival (A) and event free survival (B), including failure and withdrawal of Imatinib (all causes included)

Cervantes F & al., Haematologica 2010; 95 :1317-1324.

CHRONIC MYELOGENOUS LEUKEMIA (3)

TREATMENT

Tyrosine kinase inhibitors (TKI)

↘ proliferation and apoptosis induction of the *BCR-ABL 1* + cell lineages

Major Molecular Response (MMR) : reduction of 3 logs of *BCR-ABL 1* by PCR

Complete Molecular Response (CMR) : reduction of 4.5 logs of *BCR-ABL 1* by PCR

Possible TKI resistance due to different mutations

Mutations during treatment → resistance to TKI. Identification by molecular biology allows to choose the best new generation TKI for further treatment

Efficacy (+ / -) of TKI in presence of the main mutations

Table after : NCCN Guidelines Version 1.2015

Mutation	Imatinib (*Glivec®*)	*Dasatinib (Sprycel®)*	*Nilotinib (Tasigna®)*	*Bosutinib (Bosulif®)*	*Ponatinib*
T315I	–	–	–	–	+[1]
V299L	–	–	+	–	
T315A	+	–	+	+	
Y253H, E255K/V, F359V/C/I	–	+	–	+	+[1]
F317L / V / C / I	–	–	+	+	+[1]

[1] Important toxicity

Hydroxyurea (HU), **α**-Interferon (**α**-IFN), pegylated **α**-Interferon

Allogeneic hemopoietic stem cell / bone marrow transplantation : only established curative treatment *(in case of TKI resistance, in acceleration and transformation phases)*

AGE BASED THERAPEUTIC SELECTION

< 60 years : in case of insufficient response to TK inhibitor allogeneic hemopoietic stem cell / bone marrow transplantation. Probability of HLA compatible sibling donor 20-30%
Possible graft from unrelated donor. 5 year survival rate : 50-70%
Relapse after transplantation treated by infusion of donor lymphocytes, *Graft vs. Leukemia (GVL) effect*

> 60 years : Imatinib, **α**-Interferon (+ Cytarabine), Hydroxyurea

ESSENTIAL THROMBOCYTHEMIA (ET)

SYMPTOMS AND CLINICAL FEATURES

Arterial or venous thrombosis
Hemorrhage by thrombopathy
Erythromelalgia
Splenomegaly (< 50%)

DIAGNOSTIC CRITERIA

1	Sustained platelet count ≥ 450 G / L[1]
2	Bone marrow biopsy : proliferation mainly of megakaryocytic lineage with increased numbers of enlarged mature megakaryocytes No significant increase or left-shift of neutrophil granulopoiesis or erythropoiesis
3	Exclusion of : PV, primary myelofibrosis, *BCR-ABL 1* + chronic myeloid leukemia, myelodysplastic syndrome[2] or other myeloid neoplasm
4	*JAK2* V617F mutation[3] present or other clonal marker[4] In absence of clonal marker exclusion of secondary thrombocytosis[5]

DIAGNOSIS REQUIRES ALL 4 CRITERIA

[1] Sustained during the work-up process

[2] Absence of dyserythropoiesis and dysgranulopoiesis

[3] 60-65% of cases

[4] *CALR* : ~ 70% of *JAK2* / *MPL negatives; MPL* W515L, W515K : 5%; other : 15%

[6] Exclusion of secondary thrombocytosis *(cf. page 131)*

Tefferi A. : Diagnosis and clinical manifestations of essential thrombocythemia; January 2015, UpToDate.

ESSENTIAL THROMBOCYTHEMIA (2)

POSSIBLE COURSE

Polycythemia Vera
Myelofibrosis *(cf. p.130)*
Acute leukemia (3-10%)

TREATMENT

Aspirin *(platelet antiaggregant)*
Hydroxyurea
Anagrelide *(could potentially favor evolution to myelofibrosis)*
α-IFN, pegylated α-IFN

MEDIAN SURVIVAL

Depending on the risk factors[1]

Age ≥ 60 years and leukocytes ≥ 15 G / L : 10 years
Age ≥ 60 years or leukocytes ≥ 15 G / L : 17 years
Age < 60 years and leukocytes < 15 G / L : 25 years

[1] *Wolanskyj A.P., Schwanger S.M., McClure R.F., Larson D.R. , Tefferi A.: Essential Thrombocythemia Beyond the First Decade : Life Expectancy, Long-term Complication Rates, and Prognostic Factors. Mayo Clin Proc 2006; 81 : 159-166.*

ESSENTIAL THROMBOCYTHEMIA (3)

Diagnostic criteria for evolution to post-PV and post-ET myelofibrosis (MF)

REQUIRED CRITERIA	1	**Documentation of a previous diagnosis of WHO-defined (2008) PV or ET**
	2	**Bone marrow fibrosis grade 2-3** *(on 0-3 scale)* *(cf .p.133)*
ADDITIONAL CRITERIA (2 required)	1	**Post-PV MF : Anemia[1] or sustained loss of either phlebotomy alone or cytoreductive treatment requirement for erythrocytosis** **Post-ET MF : Anemia[1] or ≥ 20 g / L decrease from baseline hemoglobin level**
	2	**Leukoerythroblastic peripheral blood picture**
	3	**Increasing palpable splenomegaly of > 5 cm from baseline** *(distance from the left costal margin)* **or newly palpable splenomegaly**
	4	**Post-ET MF : Increased LDH**
	5	**Development of > 1 of 3 constitutional symptoms :** **weight loss > 10% in 6 months, night sweats, unexplained fever (> 37.5°C)**

[1] **Below reference range for appropriate age, gender and altitude**

Swerdlow S.H., Campo E., Harris N.L., Jaffe E.S., Pileri S.A., Stein H., Thiele J., Vardiman J.W. : WHO Classification of Tumours of Haematopoietic and Lymphoid Tissues, 4th ed. 2008; IARC, Lyon.

DIFFERENTIAL DIAGNOSIS OF THROMBOCYTOSIS

DEFINITION

Platelet count > 350 - 400 G / L

CAUSE OF ERROR

Important RBC microcytosis, presence of numerous schistocytes

CLASSIFICATION

PRIMARY THROMBOCYTOSIS

Myeloproliferative neoplasm *(cf. p.119-135)*

Essential thrombocythemia, Polycythemia Vera, chronic myelogenous leukemia, primary myelofibrosis

Myelodysplastic syndrome *(cf. p.137-146)*

5q- syndrome

SECONDARY THROMBOCYTOSIS

- Iron deficiency
- Splenectomy, asplenia[1]
- Surgery
- Infection, inflammation
- Autoimmune disorder
- Metastatic cancer
- Lymphoid neoplasm
- Acute phase / regeneration of acute hemorrhage or hemolysis

[1] Presence of Howell-Jolly bodies in RBC

PRIMARY MYELOFIBROSIS (PMF)
DIAGNOSIS

MAJOR CRITERIA	**1**	**Proliferation of atypical megakaryocytes[1] with either reticulin and / or collagen fibrosis or :** **In absence of significant reticulin fibrosis, megakaryocyte changes + increased marrow cellularity with granulocytic proliferation and often decreased erythropoiesis** *(i.e. prefibrotic cellular-phase disease)*
	2	**Exclusion of : PV, *BCR-ABL 1* + CML, MDS[2] or other myeloid neoplasms**
	3	**Presence of *JAK2* V617F mutation or other clonal marker[3] or *:*** **In absence of clonal marker, exclusion of bone marrow fibrosis or changes secondary to infection, autoimmune disorder or other chronic inflammatory condition, hairy cell leukemia or other lymphoid neoplasm, metastatic malignancy or toxic** *(chronic)* **myelopathy**
MINOR CRITERIA	**1**	**Leukoerythroblastosis**
	2	**Increased serum lactate dehydrogenase (LDH) level**
	3	**Anemia[5]**
	4	**Splenomegaly[5]**

[1] Small to large megakaryocytes in dense clusters with aberrant nuclear / cytoplasmic ratio and hyperchromatic, bulbous, or irregularly folded nuclei

[2] Absence of dyserythropoiesis and dysgranulopoiesis

[3] *JAK2* : 60-65%, *MPL* : 10%, *CALR* : ~ 90% of *JAK2* / *MPL* negatives; others : 10%

[4] Conditions associated with reactive myelofibrosis do not exclude PMF. Diagnosis to be considered if other criteria are met

[5] Variable degree of anomaly, borderline or marked

DIAGNOSIS : ALL 3 MAJOR + 2 MINOR CRITERIA

Tefferi A. : Clinical manifestations and diagnosis of primary myelofibrosis; January 2014, UpToDate.

PRIMARY MYELOFIBROSIS (2)

BLOOD COUNT : **RBC, WBC and platelet counts in relation with disease stage**
Tear drop RBC *(dacryocytes)*, **erythroblastosis and myelocytosis, platelet anisocytosis**

SEMIQUANTITATIVE GRADING OF BONE MARROW FIBROSIS (MF)

MF - 0	Scattered linear reticulin with no intersections *(cross-overs)*, corresponding to normal bone marrow
MF - 1	Loose network of reticulin with many intersections, especially in perivascular areas
MF - 2	Diffuse and dense increase in reticulin with extensive intersections, occasionally with focal bundles of collagen and / or focal osteosclerosis
MF - 3	Diffuse and dense increase in reticulin with extensive intersections and coarse bundles of collagen, often associated with osteosclerosis

Factors :
1) ***Fever, night sweats weight loss*** > 10%
2) ***Age > 65 ans***
3) ***Hb < 100 g / L***
4) ***Leukocytes*** > 25 G / L
5) ***Blasts (PB) ≥ 1%***

IPSS SCORE (International Prognostic Scoring System)[1]

Risk groups	Number of factors	% of patients (n = 1054)	Median survival (months)
Low	0	22	135
Intermediate-1	1	29	95
Intermediate-2	2	28	48
High	≥ 3	21	27

COMPLICATIONS

Splenic infarction
Infections *(neutropenia)*
Bleeding *(thrombocytopenia and / or platelet anomalies)*
Acute leukemia (5-30%)

TREATMENT

Wait and watch
Hydroxyurea, transfusion support
Sectorial splenic radiotherapy, splenectomy
Allogeneic bone marrow transplantation with non myeloablative conditioning
Pegylated α-Interferon; Thalidomide, Lenalidomide (± prednisone), Pomalidomide *(immunomodulators)*
Etanercept *(TNF-α inhibitor)*
Ruxolitinib *(selective JAK1/JAK2 inhibitor)*

[1] *Cervantes F. et al : New prognostic scoring system for primary myelofibrosis based on a study of the Intenational Working Group for Myelofibrosis Research and Treatment. Blood 2009; 113 : 2895-2901.*

CHRONIC NEUTROPHILIC LEUKEMIA (CNL)

MAJOR CRITERIA	
A1	Leukocytes (peripheral blood : PB) ≥ 13 G / L
A2	Neutrophils (PB) > 80%
A3	Presence of *CSF3R* T618I mutation or other membrane-proximal mutation of gene *CSF3R*

Diagnosis requires A1 + A2 + A3 or A1 + A2 + B1 - B5

MINOR CRITERIA	
B1	Bone marrow : hypercellular, increased granulocyte precursors without left shift, nor signs of dysgranulopoiesis
B2	Peripheral blood : immature neutrophils < 10%, myeloblasts < 2%, monocytes ≤ 1.0 G / L (or < 10%), absence of dysgranulopoiesis
B3	Presence of a clonal marker or absence of features for reactive neutrophilia
B4	Absence of *BCR-ABL 1*
B5	Absence of criteria for another myeloid neoplasm

Modified from Tefferi et al.: Leukemia 2014; 28 : 1407-1413.

CHRONIC EOSINOPHILIC LEUKEMIA (CEL), NOS[1]

1	Eosinophilia ≥ 1.5 G / L
2	No *BCR-ABL1* fusion gene or other myeloproliferative neoplasm or myelodysplastic / myeloproliferative neoplasm
3	No *FIP1L1-PDGFRA* fusion gene *(or other rearrangement of PDGFRA),* no rearrangement of *PDGFRB* or *FGFR1*
4	Blast cell count in peripheral blood and bone marrow < 20%, no inv(16)(p13.1q22), t(16;16)(p13.1;q22), no other feature diagnostic of acute myeloid leukemia (AML)
5	Presence of a clonal or molecular genetic abnormality or blasts > 2% in PB or > 5% in bone marrow

If these criteria are not met, the diagnosis may be reactive eosinophilia, idiopathic hypereosinophilia or idiopathic hypereosinophilic syndrome (HES) *(cf. p. 99)*

[1]NOS : Not Otherwise Specified

MASTOCYTOSIS

CLASSIFICATION

Cutaneous mastocytosis *(urticaria pigmentosa)*, **diffuse or solitary cutaneous mastocytosis**
Systemic mastocytosis *(indolent or aggressive)*
Mastocytic leukemia
Mastocytic sarcoma
Extracutaneous mastocytoma

SYSTEMIC MASTOCYTOSIS

Clonal mastocyte proliferation *(tissue basophils)*
with secretion of tissular mediators : Histamine, heparin, leukotrienes, prostaglandins, PAF (Platelet Activating Factor), Cytokines (TNF)

Target organs : **Bone marrow**
Lymph nodes
Spleen, liver
Heart

Presence of cutaneous localisation or not
Osteoblastic bone lesions, less frequently osteolytic

Symptoms : **Cutaneous flash, pruritus**
Abdominal pain
Bronchospasm

Evolution : **Indolent forms**
Aggressive forms Initially
Mastocytosis associated with myeloid or lymphoid neoplasia
Mastocytic leukemia

Treatment : **Antihistamines, α-Interferon, tyrosine kinase inhibitors, anti-leukotrienes**

Survival : **Nearly normal for indolent forms**
Few months for aggressive forms

Biochemistry :
⇗ of serum tryptase

Immunophenotype :
CD9 +, CD33 +, CD45 +, CD68 +, CD117 +, CD2 + ou CD2 / CD25 +

Genetics :
Mutations of *KIT* (mostly D816V) : > 95% of cases

MYELOID AND LYMPHOID NEOPLASMS WITH EOSINOPHILIA AND ANOMALIES OF *PDGFRA*, *PDGFRB* OR *FGFR1*

MYELOID AND LYMPHOID NEOPLASMS WITH *PDGFRA* REARRANGEMENT	
1	Myeloproliferative neoplasm with prominent eosinophilia
2	Presence of *FIP1L1-PDGFRA* fusion gene
Acute myeloid leukemia and lymphoblastic leukemia / lymphoma with eosinophilia and *FIP1L1-PDGFRA* are also assigned to this category. If molecular analysis is not available, diagnosis is suspected if : 1) Ph-negative myeloproliferative neoplasm with features of chronic eosinophilic leukemia; 2) splenomegaly; 3) high level of vitamin B_{12}; 4) increase of serum tryptase; 5) increase of BM mast cells	
Tyrosine Kinase activity : disease is responsive to TK- inhibitors *(Imatinib mesylate)*	

MYELOID NEOPLASMS WITH *PDGFRB* REARRANGEMENT	
1	Myeloproliferative neoplasm often with prominent eosinophilia, sometimes neutrophilia or monocytosis
2	Presence of t(5;12)(q33;p13) or variant translocation. Demonstration of *ETV6-PDGFRB* fusion gene or of rearragement of *PDGFRB*
Hematological features : chronic myelomonocytic leukemia with / without eosinophilia, chronic eosinophilic leukemia, Ph-neg. chronic myelogenous leukemia with eosinophilia, primary myelofibrosis, juvenile myelomonocytic leukemia with eosinophilia, acute myelogenous leukemia, chronic basophilic leukemia	

MYELOID AND LYMPHOID NEOPLASMS WITH *FGFR1* ANOMALIES	
1	Myeloproliferative neoplasm with prominent eosinophilia and sometimes neutrophilia or monocytosis or acute myeloid leukemia or precursor T- or B-cell lymphoblastic leukemia / lymphoma *(often associated with peripheral blood or bone marrow eosinophilia)*
2	Presence of t(8;13)(p11;q12) or variant translocation with *FGFR1* rearrangement in myeloid cells, lymphoblasts or both

MYELODYSPLASTIC SYNDROMES (MDS)
GENERAL FEATURES

Somatic mutation of a hemopoietic stem cell upstream of myeloid precursor cells

Myelodyplasia *(dysmyelopoiesis)* **:**

Proliferation	**+ / -**
Maturation	**+ / -**
Apoptosis	**+**

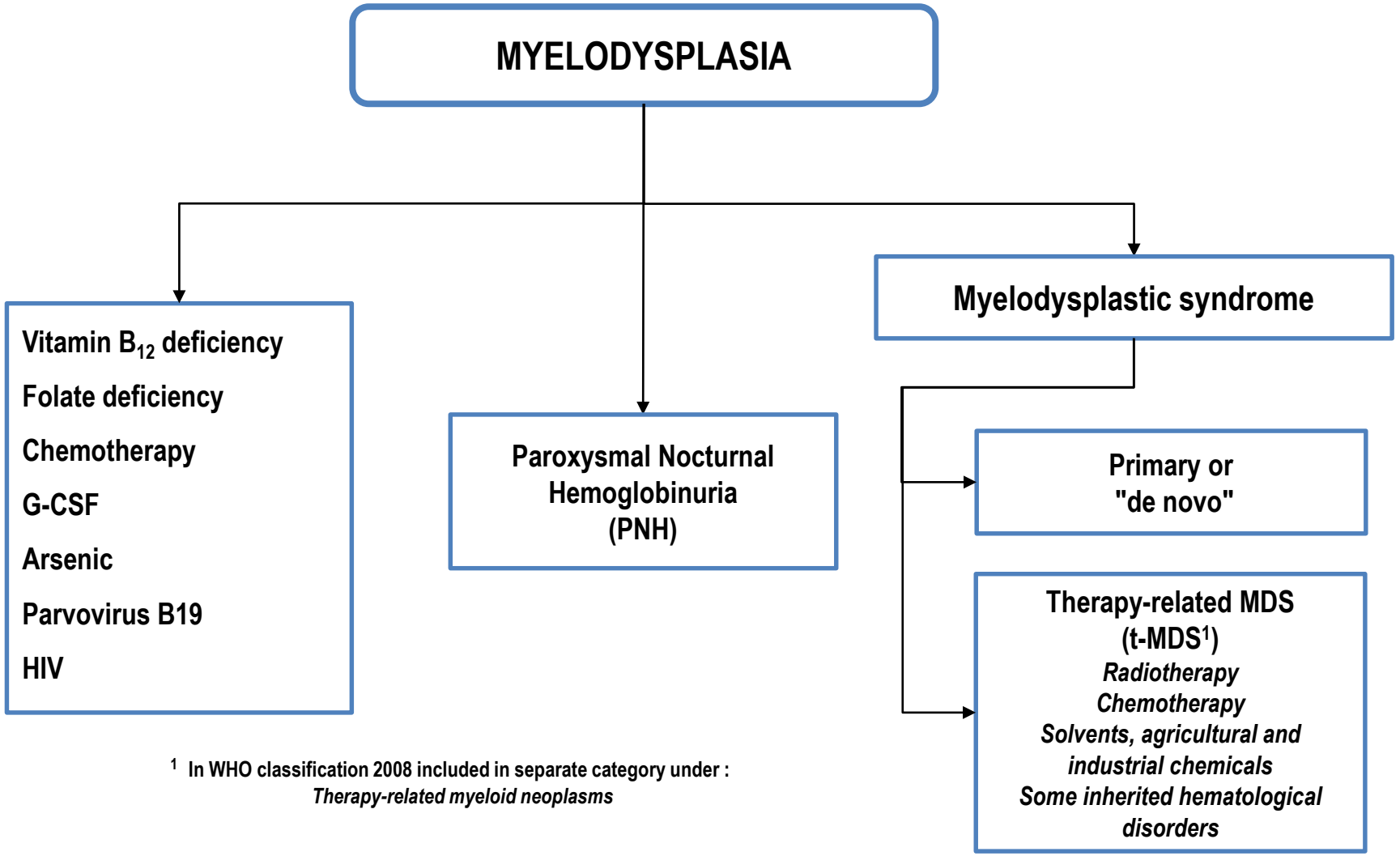
Peripheral blood with 1-3 cytopenia(s)

WHO classification considering :

- **Presence of of dysplasia signs affecting only one** *("unilineage")* **or more cell lineages** *("multilineage")*
- **Blast cells in peripheral blood or bone marrow : < 20%**
- **Presence or absence of Auer rods**
- **Presence or absence of ring sideroblasts : < 15% or ≥ 15%** *(bone marrow)*
- **Peripheral blood monocytosis < 1.0 G / L**

Possible transformation in acute leukemia

MYELODYSPLASIA



[1] In WHO classification 2008 included in separate category under :
Therapy-related myeloid neoplasms

MORPHOLOGICAL SIGNS OF MYELODYSPLASIA
DYSMYELOPOIESIS

	PERIPHERAL BLOOD	BONE MARROW
Dyserythropoiesis	Macrocytosis *(frequent)* Anisocytosis Poikilocytosis Anisochromasia Coarse basophilic granules	Nuclear Megaloblastic changes Nuclear budding, internuclear bridging Karyorrhexis, hyperlobation Cytoplasmic Vacuolization Ring Sideroblasts (RS) Periodic acid-Schiff (PAS) staining +
Dysgranulopoiesis	Small or unusually large size Pseudo-Pelger Irregular hypersegmentation Decreased granules or agranularity Pseudo Chediak-Higashi granules Auer rods	
Dysmegakaryopoiesis (platelets)	Giant platelets Lack of granules	Micromegakaryocytes Hypolobated nuclei Multinucleated megakaryocytes

CLASSIFICATION OF MDS

PERIPHERAL BLOOD AND BONE MARROW FEATURES

DISEASE	PERIPHERAL BLOOD	BONE MARROW
Refractory Cytopenias with Unilineage Dysplasia (RCUD) : RA, RN, RT[1]	Unicytopenia (rarely bicytopenia) No or rare blasts (< 1%)[2]	Unilineage dysplasia : ≥ 10% of cells in one myeloid lineage; blasts < 5% Ring Sideroblasts (RS) < 15%
Refractory Anemia with Ring Sideroblasts (RARS)	Anemia No blasts	Erythroid dysplasia only Ring Sideroblasts ≥ 15%, blasts < 5%
Refractory Cytopenia with Multilineage Dysplasia (RCMD)	Cytopenia(s), no or rare blasts (< 1%)[2] No Auer rods Monocytes < 1 G / L	Dysplasia in ≥ 10% of cells in ≥ 2 myeloid lineages, blasts < 5%, no Auer rods Ring Sideroblasts ± 15%
Refractory Anemia with Excess Blasts-1 (RAEB-1)	Cytopenia(s), blasts < 5%, no Auer rods Monocytes < 1 G / L	Uni- or multilineage dysplasia, blasts 5-9% No Auer rods
Refractory Anemia with Excess Blasts-2 (RAEB-2)	Cytopenia(s), blasts 5-19%, Auer rods ±[3] Monocytes < 1 G / L	Uni- or multilineage dysplasia Blasts 10-19%, Auer rods ±[3]
Myelodysplastic Syndrome - Unclassified (MDS-U)	Cytopenias Blasts ≤ 1%	Evident dysplasia in less than 10% of cells in one or more myeloid cell lines with MDS cytogenetic anomaly, blasts < 5%
Myelodysplastic Syndrome associated with isolated del(5q)	Anemia Normal or increased platelet count No or rare blasts (< 1%)	Normal or increased megakaryocytes with hypolobulated nuclei, blasts < 5%, no Auer rods, isolated del(5q)

[1] RA : Refractory Anemia; RN : Refractory Neutropenia; RT : Refractory Thrombocytopenia

[2] If bone marrow blast percentage < 5%, but 2-4% blasts are present in the blood, the diagnostic is RAEB-1. RCUD and RCMD with 1% blasts in blood are classified as MDS-U

[3] Cases with Auer rods and < 5% blasts in blood and < 10% in bone marrow are classified as RAEB-2

DIFFERENTIAL DIAGNOSIS OF MYELODYSPLASTIC SYNDROME AND ACUTE MYELOID LEUKEMIA

IMPORTANCE OF BONE MARROW ERYTHROBLASTS PERCENTAGE

ERYTHROBLASTS (in % of total nucleated bone marrow cells)			
< 50%		≥ 50%	
Blasts in % of total nucleated bone marrow cells		Blasts in % of non erythroid nucleated bone marrow cells	
≥ 20%	< 20%	< 20%	≥ 20%
AML	MDS		AML

Modified from Bennett J.M. & al. : Proposed revised criteria for the classification of acute myeloid leukemia. Ann Intern Med 1985; 103 : 620-625. Modifications according to WHO classification 2008.

AML : Acute Myeloid Leukemia

MDS : Myelodysplastic Syndrome

ANOMALIES RELATED TO MYELODYSPLASTIC SYNDROME

FUNCTIONAL ALTERATIONS	Neutrophils : Motility, adhesion, phagocytosis, bactericidal ability Platelets : Aggregation
IMMUNOLOGICAL DISORDERS	Polyclonal gammopathy Hypogammaglobulinemia Paraprotein Autoantibodies Decreased counts of CD4 + and NK lymphocytes
ACQUIRED HEMOGLOBINOPATHY	α-Thalassemia Myelodysplastic Syndrome (ATMDS)

MYELODYSPLASTIC SYNDROMES
IPSS PROGNOSTIC SCORE

Prognostic score evaluates the risk of leukemic transformation of primary MDS

Score	0	0.5	1.0	1.5	2.0
Cytopenia(s)	0 – 1	2 – 3			
Blasts[1] (%)	< 5	5 – 10	–	11 – 19	20 – 30[2]
Karyotype	Favorable	Intermediate	Unfavorable		

Risk groups	Score
Low	0
Intermediate-1	0.5 – 1.0
Intermediate-2	1.5 – 2.0
High	≥ 2.5

[1] Blasts in bone marrow [2] This percentage is now considered as AML according to WHO 2008

Cytopenia(s) : Hemoglobin < 100 g / L
Neutrophils < 1.8 G / L
Platelets < 100 G / L

Karyotype : Favorable : Normal karyotype, -Y, del(5q), del(20q)
Unfavorable : Chromosome 7 anomalies, complex anomalies (≥ 3)
Intermediate : Other anomalies

MYELODYSPLASTIC SYNDROMES
IPSS SCORE REVISED 2012 (IPSS - R)

❶ PROGNOSTIC IMPACT OF CYTOGENETIC ANOMALIES

CYTOGENETIC PROGNOSTIC GROUPS	CYTOGENETIC ANOMALIES
Very good	• - Y • del(11q)
Good	• none • unique anomaly del(5q) del(12p) del(20q) • double anomaly, included del(5q)
Intermediate	• del(7q) • +8 • +19 • i(17q) • every other unique or double anomaly, independant clones
Unfavorable	• -7 • inv(3) • t(3q) • del(3q) • double anomaly included -7 / del(7q) • complex anomalies
Very unfavorable	• > 3 complex anomalies

❷ SCORE CALCULATION

Adding points corresponding to actual prognostic criteria

PROGNOSTIC CRITERIA	0	0.5	1.0	1.5	2.0	3.0	4.0
Cytogenetics	Very good		Good		Intermediate	Unfavorable	Very unfavorable
Blasts bone marrow (%)	≤ 2		> 2 - < 5		5 - 10	> 10	
Hemoglobin (g / L)	≥ 100		8 - < 10	< 8			
Platelets (G / L)	≥ 100	50 - < 100	< 50				
Neutrophils (G / L)	≥ 0.8	< 0.8					

❸ PROGNOSTIC RISK related to score

PROGNOSTIC RISK	SCORE
Very low	≤ 1.5
Low	> 1.5 – 3.0
Intermediate	> 3.0 – 4.5
High	> 4.5 – 6.0
Very high	> 6.0

A IPSS-R calculator can be found on the MDS-Foundation Website. This calculator takes also in account the age of the patient for estimation of survival :

http://www.mds-foundation.org/ipss-r-calculator/

❹ PROGNOSTIC IMPACT OF IPSS-R SCORE

RISK	Very low	Low	Intermediate	High	Very high
SURVIVAL					
Patients (n = 7012) (%)	19	38	20	13	10
Median survival (years)	8.8	5.3	3.0	1.6	0.8
EVOLUTION TO AML					
Patients (n = 6485) (%)	19	37	20	13	11
Median duration → 25% evolution to AML (years)	Not reached	10.8	3.2	1.4	0.73

D'après Greenberg P.L & al.: Revised International Prognostic Scoring System for Myelodysplastic Syndromes. Blood 2012; 120 : 2454 - 2465.

MYELODYSPLASTIC SYNDROMES
UNFAVORABLE PROGNOSTIC FACTORS

Age > 60 years	**⇗ Serum β_2-microglobulin**
Performance status / comorbidities	**Mutations of : *ASXL1, RUNX1, EZH2, ETV6, TP53 genes***
White blood cells > 20 G / L	**⇗ TNF-α level**
Lymphocytes < 1.2 G / L	**Transfusion dependency**
Severe anemia	**Bone marrow fibrosis**
Refractory thrombocytopenia	**Low level of circulating endothelial cells**
High percentage of CD34 expressing precursor cells	**Increased expression of *WT1*** *(Wilms tumor gene)*
MCV < 100 fL	**Presence of ALIPs** *(Abnormal Localization of Immature Precursors)* **on BM histology**

[1] After NCCN (National Comprehensive Cancer Network) guidelines V2.2014 : Myelodysplastic Syndromes.

MYELODYSPLASTIC SYNDROMES
COMPLICATIONS / COURSE / SURVIVAL

COMPLICATIONS

Recurrent infection
Bleeding episodes
Immunologic disorders

5 YEAR CUMULATIVE RISK OF TRANSFORMATION IN ACUTE LEUKEMIA[1]

RA, RARS :	< 2%
RCMD, 5q- syndrome :	~ 10%
RAEB-1 :	11%
RAEB-2 :	40%

RA : Refractory anemia
RARS : Refractory Anemia with Ring Sideroblasts
RCMD : Refractory Cytopenia with Multilineage Dysplasia
RAEB : Refractory Anemia with Excess Blasts

SURVIVAL RELATED TO PROGNOSTIC SCORE

IPSS-R[2]

Score	≤ 1.5	8.8 years
Score	> 1.5-3.0	5.3 years
Score	> 3.0-4.5	3.0 years
Score	> 4.5-6.0	1.6 year
Score	> 6.0	0.8 year

[1] *Germing U., Strupp C., Kuendgen A., Isa S., Knipp S., Hildebrandt B., Giaconidis A., Aul C., Gattermann N., Haas R.: Prospective validation of the WHO proposals for the classification of myelodysplastic syndromes. Haematologica 2006; 91 : 1596-1604.*

[2] *Greenberg P.L. & al. : Revised International Prognostic Scoring System for Myelodysplastic Syndromes. Blood 2012; 120 : 2454 - 2465.*

TREATMENT OF MYELODYSPLASTIC SYNDROME

SYMPTOMATIC TREATMENT

Transfusional supportive care *(RBC, platelets)*
Iron chelators *(oral or parenteral application)*
Antibiotics
Erythropoietin + G-CSF, IL-11 *(⇗platelets[1])*

CHEMOTHERAPY

Antimetabolites : Azacitidine, Decitabine, Cytarabine
Antiangiogenic, anticytokine drugs : Thalidomide, Lenalidomide *(5q- syndrome)*

IMMUNOSUPPRESSIVE THERAPY (Hypocellular MDS) : ATG *(Anti-Thymocyte Globulin)* ± cyclosporin

ALLOGENEIC STEM CELL / BONE MARROW TRANSPLANTATION

(< 60 years, HLA identical donor, possibly with reduced intensity conditioning)

Investigational :
TNF-α inhibitors *(Etanercept)*
Arsenic trioxide
Histone deacetylase inhibitors *(Valproic acid)*
Farnesyltransferase inhibitors

[1] **Thrombopoietin analogues (*Romiplostim)* should be proscribed due to the increased risk of MDS transformation to AML**

Myelodysplastic Syndrome : Etiology, Natural History, Current and Future Therapies, Rowe J.M. ed., Clinical Haematology 2004; 17 : 535-661.

MYELODYSPLASTIC / MYELOPROLIFERATIVE NEOPLASMS (MDS / MPN)

CLASSIFICATION

CHRONIC MYELOMONOCYTIC LEUKEMIA
ATYPICAL CHRONIC MYELOID LEUKEMIA, *BCR-ABL 1* NEGATIVE
JUVENILE MYELOMONOCYTIC LEUKEMIA
REFRACTORY ANEMIA WITH RING SIDEROBLASTS (RARS) ASSOCIATED WITH THROMBOCYTOSIS
MYELODYSPLASTIC / MYELOPROLIFERATIVE NEOPLASM, UNCLASSIFIABLE

CHRONIC MYELOMONOCYTIC LEUKEMIA

DIAGNOSTIC CRITERIA

1. **Persistent peripheral blood monocytosis > 1.0 G / L**
2. **Absence of Philadelphia chromosome or *BCR-ABL 1* fusion gene**
3. **No rearrangement of *PDGFRA*, *PDGFRB*** *(should be specifically excluded in cases with eosinophilia)*
4. **< 20% blasts** *(myeloblasts, monoblasts and promonocytes)* **in peripheral blood and in the bone marrow**
5. **Signs of dysplasia in one or more myeloid lineage(s)**

   If dysplasia minimal or absent : 1 + 2 + 3 + 4 with :

   Presence of acquired cytogenetic or molecular anomaly or :

   persisting monocytosis (> 3 months) and exclusion of any other cause of monocytosis *(cf. p.102)*

VARIANTS : **CMML-1 : blasts** *(and promonocytes)* **< 5%** *(peripheral blood)*, **< 10%** *(bone marrow)*
CMML-2 : blasts *(and promonocytes)* **5-19%** *(peripheral blood)*, **10-19%** *(bone marrow)* **or presence of Auer rods**

UNFAVORABLE PROGNOSTIC CRITERIA : Monocytes > 10 G / L, Hgb < 100 g / L, platelets < 100 G / L, myelemia (*Mayo CMML prognostic model)*, mutation of *ASXL 1*

EVOLUTION : **Progression to acute myeloid leukemia : 15-30%**
Median survival : 16-97 months[1]

[1] *Patnaik MM. et coll. : ASXL1 and SETBP1 mutations and their prognostic contribution in chronic myelomonocytic leukemia : a two-center study of 466 patients. Leukemia 2014; 28 : 2206-2212.*

ACUTE MYELOID LEUKEMIA (AML)
EPIDEMIOLOGY

IONIZING RADIATION

ALKYLATING AGENTS

BENZENE AND DERIVATIVES

MYELOPROLIFERATIVE NEOPLASMS (MPN)

MYELODYSPLASTIC SYNDROMES (MDS)

MYELODYSPLASTIC / MYELOPROLIFERATIVE NEOPLASMS (MDS / MPN)

TRISOMY 21

PRIMITIVE IMMUNODEFICIENCY

FANCONI ANEMIA *(bone marrow aplasia of genetic origin)*

PAROXYSMAL NOCTURNAL HEMOGLOBINURIA

CLINICAL FEATURES OF ACUTE MYELOID LEUKEMIA

SIGNS OF BONE MARROW FAILURE

Anemia	→	fatigue, dyspnea
Neutropenia	→	infection
Thrombocytopenia	→	hemorrhage

TUMORAL SIGNS DUE TO BLASTIC INFILTRATION

Frequently absent
Gingival involvement[1]
Cutaneous involvement[1]
Neuromeningeal involvement[1]
Lymphadenopathy, splenomegaly

LEUKOSTASIS

Acute leukemia with hyperleukocytosis, most frequently with monocytic component

OTHER DISORDERS

Lysozyme tubulopathy[1]
Uric nephropathy
Electrolytic disorders *(⇗K^+, ⇗Ca^{++})*

[1] Acute myelomonocytic, monoblastic or monocytic leukemia

ACUTE MYELOID LEUKEMIA
BONE MARROW AND PERIPHERAL BLOOD

BONE MARROW

≥ 20 % BLASTS

PERIPHERAL BLOOD

PERIPHERAL BLOOD		1	2	3	4	5
HEMOGLOBIN	g / L	78	117	82	97	56
MCV	fL					112
WBC	G / L	320	0.9	7.6	115	3.1
PLATELETS	G / L	12	12	97	426	76

1. **Acute myeloid leukemia with very high WBC count** *(hyperleukocytosis)*
2. **Aleukemic acute myeloid leukemia** *(absence of blasts or rare blasts in peripheral blood)*
3. **Acute myeloid leukemia with normal WBC count** *(blasts : 85% in peripheral blood)*
4. **Acute transformation of myeloproliferative neoplasm** *(persisting thrombocytosis)*
5. **Acute transformation of myelodysplastic syndrome** *(macrocytosis !)*

ACUTE MYELOID LEUKEMIA
WHO CLASSIFICATION 2008

CRITERIA

CYTOLOGY - CYTOCHEMISTRY - IMMUNOPHENOTYPING - CYTOGENETICS - MOLECULAR BIOLOGY

CLASSIFICATION

ACUTE MYELOID LEUKEMIA WITH RECURRENT GENETIC ANOMALIES

Cytogenetics	Rearrangement	Hematological features
t(8;21)(q22;q22)	***RUNX1-RUNX1T1***	AML generally with neutrophil lineage maturation
inv(16)(p13.1q22) ou t(16;16)(p13.1;q22)	***CBFB-MYH11***	Myelomonocytic AML with abnormal bone marrow eosinophils
t(15;17)(q24;q21)	***PML-RARA***	Acute promyelocytic leukemia and microgranular variant
t(9;11)(p22;q23)	***MLLT3-MLL*** ***KMT2A (MLL)***	AML usually associated with monocytic differentiation
t(6;9)(p23;q34)	***DEK-NUP214***	AML frequently with basophilia, multilineage dysplasia ± monocytosis
inv(3)(q21q26.2) or t(3;3)(q21;q26.2)	***RPN1-*** ***MECOM (EVI1)***	AML with often normal or ⇗ platelet count in peripheral blood; ⇗ of atypical megakaryocytes in the bone marrow; multilineage dysplasia
t(1;22)(p13;q13)	***RBM15-MKL1***	Peripheral blood and bone marrow similar to the acute megakaryoblastic leukemia NOS[1] *(cf. p.154)*
Provisional entities : AML with NPM1 or CEBPA mutations **(normal karyotype)** *(cf. p.155)*		

[1]**NOS : Not Otherwise Specified**

ACUTE MYELOID LEUKEMIA
WHO CLASSIFICATION 2008 (2)

ACUTE MYELOID LEUKEMIA WITH MYELODYSPLASIA RELATED CHANGES
- AML from previous MDS or MDS / MPN
- AML with MDS-related cytogenetic anomaly
- AML with multilineage dysplasia

THERAPY-RELATED MYELOID NEOPLASMS (t-AML, t-MDS, t-MDS / MPN)
- Alkylating agents, ionizing radiation therapy, topoisomerase II inhibitors, antimetabolites, antitubulin agents

ACUTE MYELOID LEUKEMIA, NOS[1]
(cf. p.153-154)
- Acute basophilic leukemia
- Acute panmyelosis with myelofibrosis

MYELOID SARCOMA

MYELOID PROLIFERATIONS RELATED TO DOWN SYNDROME

BLASTIC PLASMACYTOID DENDRITIC CELL NEOPLASM

ACUTE LEUKEMIAS OF AMIBIGUOUS LINEAGE
- Acute undifferentiated leukemia
- Mixed phenotype acute leukemia with t(9;22)(q34;q11.2); *BCR-ABL 1* : B (or T) and myeloid lineages
- Mixed phenotype acute leukemia with t(v;11q23); *MLL* rearranged
- Mixed phenotype acute leukemia B / myeloid, NOS[1]
- Mixed phenotype acute leukemia T / myeloid, NOS[1]

[1] NOS : Not Otherwise Specified

ACUTE MYELOID LEUKEMIA
WHO CLASSIFICATION 2008 (3)

ACUTE MYELOID LEUKEMIA , NOS

With minimal differentiation :	**Blasts ≥ 20% of NMC[1], P[2] + and SB[3] + < 3%, presence of myeloid markers : CD34 +, CD13 + and / or CD117 +, CD33 + (60%); T-marker : CD7 + (40%)**
Without maturation :	**Blasts ≥ 90% of NENC[4], P + and SB + ≥ 3%, promyelocytes → neutrophils ≤ 10% of NENC, CD34 +, CD13 +, CD33 +, CD117 +, generally CD15 -, CD65 -**
With maturation :	**Blasts 20-89% of NENC, P +, SB +, promyelocytes → neutrophil ≥ 10% of NENC, CD34 +, CD13 +, CD33 +, CD65 +, CD11b +, CD15 +**
With myelomonocytic differentiation :	**Blasts 20-79% of NENC. Monoblasts → monocytes ≥ 20% of NENC and / or monocytosis in peripheral blood ≥ 5 G / L, P+, ANBE[5] +, DE[6] +, CD34 +, CD13 +, CD33 +, CD65 +, CD15 + [monocytic differentiation : CD14 +, CD4 +, CD11b +, CD11c +, CD64 +, CD36 +, CD68 + (PGM1[7]), CD163 +, lysozyme +]**

[1] NMC : Nucleated Marrow Cells; [2] P : Peroxydase; [3] SB : Sudan Black; [4] NENC : Non Erythroid Nucleated Cells
[5] ANBE : α-naphtyl-butyrate esterase; [6] DE : double esterase ANBE + CAE *(chloroacetate esterase)*; **[7] PGM1 : phosphoglucomutase 1**

ACUTE MYELOID LEUKEMIA
WHO CLASSIFICATION 2008 (4)

ACUTE MYELOID LEUKEMIA, NOS (2)

With monoblastic or monocytic differentiation :	***Monoblastic :*** **Monoblasts ≥ 80% of NENC[1]** ***Monocytic :*** **Monoblasts < 80% of NENC, presence of promonocytes and monocytes, P[2] ± , ANBE[3] +, CD34 +, CD13 +, CD33 +, CD15 +, CD65 +, CD14 +, CD4 +, CD11b +, CD11c +, CD64 +, CD68 +, CD36 +, lysozyme +**
With erythroblastic differentiation :	***Erythroleukemia*** *(Erythroid / myeloid)* ***:*** **≥ 50% erythroid precursors** *(with signs of dysplasia, PAS[4] ±, glycophorin +)* **of NMC[5] , ≥ 20% myeloblasts of NENC** *(myeloid markers of AML minimal or without differentiation)* ***Pure erythroid leukemia :*** **≥ 80% of dysplastic erythroid precursors** *(basophilia, vacuoles, PAS +, glycophorin +)*, **without myeloblastic component**
With megakaryoblastic differentiation :	**Blasts ≥ 20% of NMC; ≥ 50% of blasts must express markers of megakaryocytic lineage : CD34 +, CD CD41 +** *(glycoprotein IIb/IIIa)* **and / or CD61 +** *(glycoprotein IIIa)*, **CD42 ±** *(glycoprotein Ib),* **vW[6] +. Other markers : CD13 ±, CD33 ±, CD36 +**

[1] NENC : Non Erythroid Nucleated Cells; [2] P : Peroxydase; [3] ANBE : α-naphtyl-butyrate esterase; [4] PAS : Periodic acid-Schiff
[5] NMC : Nucleated Marrow Cells; [6] vW : von Willebrand

PROGNOSTIC FACTORS IN ACUTE MYELOID LEUKEMIA

		FAVORABLE	UNFAVORABLE
Age		< 50 y	> 60 y
Karnofsky[1] Index		> 60%	< 60%
Phenotype		MDR1[2] neg	MDR1[2] pos
Leukocytes (WBC)		< 30 G / L	> 30 G / L
Post chemo- and / or radiotherapy Prior hematological disorder (MPN, MDS, other)		No	Yes
Cytogenetics		t(8;21), inv(16) / t(16;16), t(15;17)	Complex karyotypic anomalies, -5, -7, t(6;9), 3q26, 11q23 aberrations *[except t(9;11)(p22;q23)]* "Monosomic karyotype" [3]
Molecular genetic alterations	Mutations	*NPM1*[4] ,*CEBPA*[5]	*FLT3*-ITD[6], *MLL*-PTD[7], *IDH1*[8], *and / or IGH2*
	Overexpression		*BAALC*[9], *EVI1*[10]
Bone marrow blasts after induction treatment		< 5%	> 20%

[1] Karnofsky Index : patient performance index, *cf. next page*; [2] MDR : Multidrug Resistance; [3] Monosomy = one copy only of a chromosome. "Monosomic karyotype" : 2 autosomal monosomies or 1 with at least one structural anomaly; [4] *NPM1* : Nucleophosmine, member 1; [5] *CEBPA* : CCAAT / Enhancer Binding Protein α; [6] *FLT3*-ITD : Fms-Like tyrosine Kinase 3-Internal Tandem Duplication *(Tyrosine kinase receptor)*; [7] *MLL*-PTD : Myeloid / Lymphoid or Mixed Lineage Leukemia-Partial Tandem Duplication; [8] IDH1 : Isocitrate dehydrogenase; [9] *BAALC* : Brain and Acute Leukemia, Cytoplasmic; [10] *EVI1* : Ecotropic Virus Integration site I

Modified from : Schiffer C.A. : Prognosis of acute myeloid leukemia; February 2015, UpToDate.

KARNOFSKY PERFORMANCE STATUS

LEVEL OF PERFORMANCE	%	CRITERIA
Normal activity No assistance needed	100	Normal, no complaints; no evidence of disease
	90	Able to carry on normal activity; minor signs or symptoms of disease
	80	Normal activity with effort; some signs or symptoms of disease
Impaired activity Ambulatory assistance needed	70	Cares for self; unable to carry on normal activity or to do active work
	60	Requires occasional assistance but is able to care for most of his / her needs
	50	Requires considerable assistance and frequent medical care
Assistance dependent Hospital care desirable	40	Disabled; requires special care and assistance
	30	Severely disabled; hospitalization is indicated although death not imminent
	20	Very sick; hospitalization necessary; active supportive treatment necessary
Terminal care	10	Moribund; fatal processes progressing rapidly
	0	Deceased

ACUTE MYELOID LEUKEMIA
THERAPEUTICAL PRINCIPLES

SUPPORTIVE CARE

TREATMENT OF INFECTION
TRANSFUSION SUPPORT (RBC, platelets)

CHEMOTHERAPY

INDUCTION
CONSOLIDATION
INTENSIFICATION

HEMOPOIETIC STEM CELL / BONE MARROW TRANSPLANTATION

ALLOGENEIC ($\rightarrow$ 60 y)

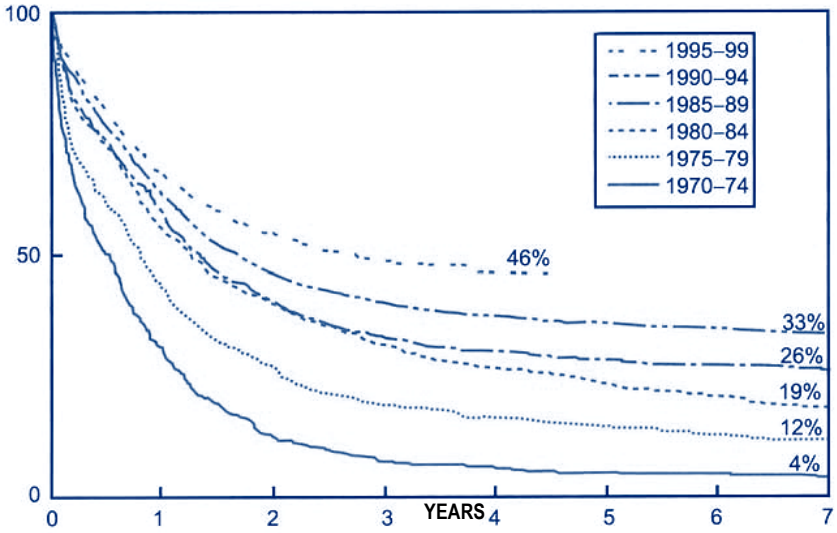
MINI-ALLO TRANSPLANT

Reduced intensity conditioning transplant

Compatible sibling donor : 20-30% of patients have an HLA identical sibling donor

Unrelated donor

AUTOLOGOUS (peripheral blood stem cells / BM)



Survival improvement for patients 15-59 years of age from 1970-1999 (UK MRC : United Kingdom Medical Research Council)

Burnett A.K. : Treatment of acute myeloid leukaemia in younger patients. Clinical Haematology 2001; 14 : 95-118.

TREATMENT OF ACUTE MYELOID LEUKEMIA[1]
CHEMOTHERAPY

Age : < 60 years

AD : Cytarabine (ARA-C) + Daunorubicin : "7 + 3"; ADC : AD + Cladribine; ADF : AD + Fludarabine; ADE : AD + Etoposide

Age : > 60 years

Cytarabine + Anthracycline (Daunorubicin, Mitoxanthrone or Idarubicin)

Complete remission rate *(after 1st or 2nd induction cycle)*, survival rate after consolidation and intensification : highly variable in relation with presence of main adverse risk factors or not *(cf. p. 155)*

Improvement of survival after autologous or allogeneic hematopoietic stem cell transplantation

(with reduced intensity conditioning for patients over 60)

Relapse free 5 year survival rate (allogeneic HLA-identical donor) : 18-59%

Acute promyelocytic leukemia t(15;17)(q24;q21); *PML-RARA*

ATRA (All Trans Retinoic Acid) + Arsenic trioxide as first line treatment

TREATMENT OF REFRACTORY OR RELAPSED DISEASE[2]

Azacitidine, Decitabine, Clofarabine, farnesyl transferase inhibitors (Tipifarnib), of MDR1[3], of BCL2[4] , of FLT3[5], of tyrosine kinase, antiangiogenic drugs (anti-VEGF : Bevacizumab), anti-CD33 (Gemtuzumab, Lintuzumab)

[1] List of drugs and their combination(s) is not exhaustive. For futher details consult : Larson R.A. : Induction therapy for acute myeloid leukemia in younger adults; September 2014, UpToDate. Treatment of acute myeloid leukemia in older adults; October 2014, UpToDate.

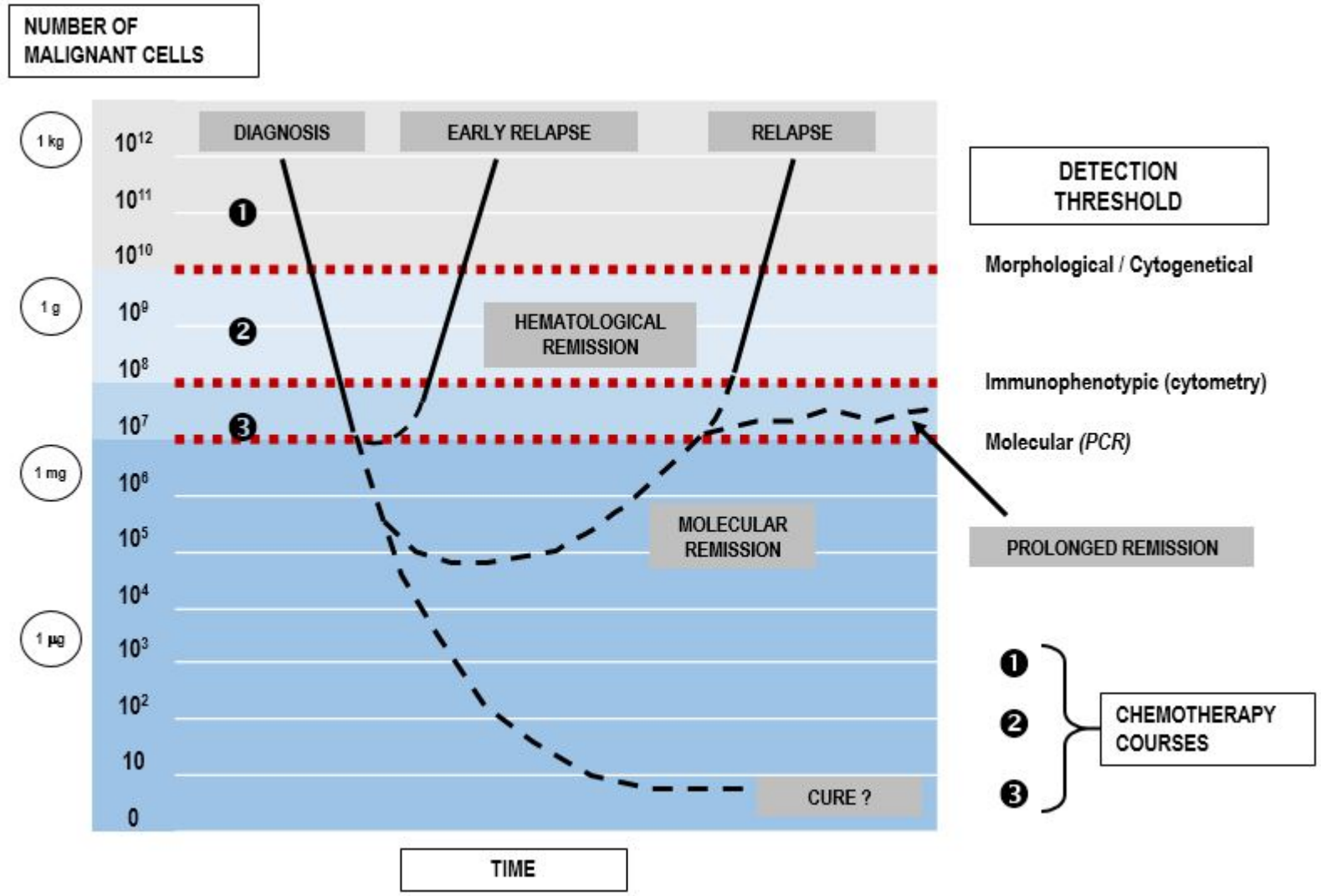
[2] Most mentioned new drugs are still on clinical trials

[3] MDR : Multidrug Resistance

[4] BCL2 : B-Cell Leukemia / Lymphoma 2 *(protooncogene, inhibitor of apoptosis)*

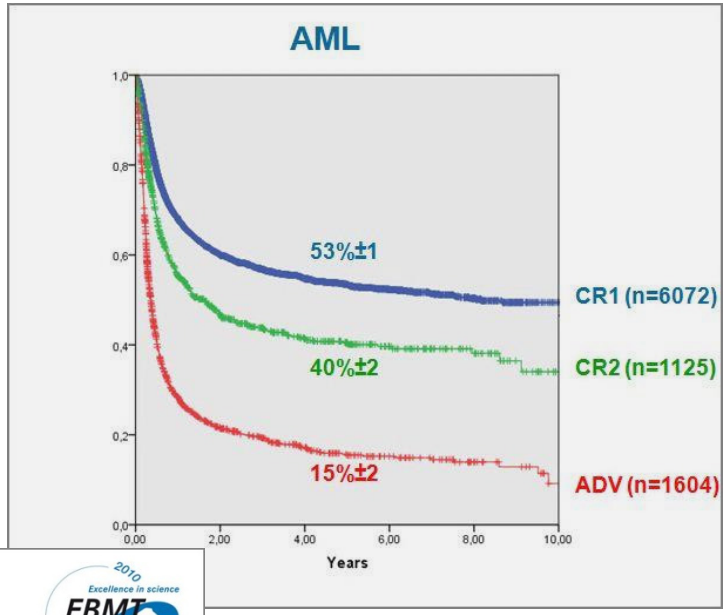
[5] FLT3 : Fms-Like tyrosine Kinase 3 *(tyrosine Kinase receptor)*

KINETICS OF LEUKEMIC CELLS UNDER TREATMENT

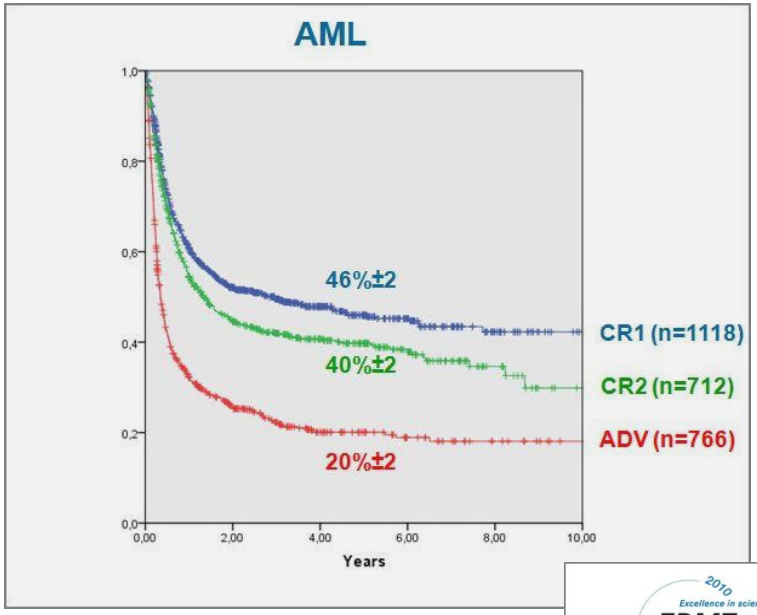


ACUTE MYELOID LEUKEMIA : ALLOGENEIC TRANSPLANTATION

ADULTS TRANPLANTED BETWEEN 1999 AND 2009
ALLOGENEIC TRANSPLANT
HLA COMPATIBLE SIBLING DONOR



ADULTS TRANSPLANTED BETWEEN 1999 AND 2009
ALLOGENEIC TRANSPLANT
UNRELATED HLA COMPATIBLE DONOR



CR 1 : First complete remission
CR 2 : Second complete remission
ADV : Advanced disease

Modified from EBMT Registry 2010 European Group for Blood and Marrow Transplantation.

LYMPHOID NEOPLASMS[1]
(WHO 2008)

PRECURSOR B-CELL OR T-CELL NEOPLASMS

B-cell lymphoblastic leukemia / lymphoma
T-cell lymphoblastic leukemia / lymphoma

MATURE B-CELL NEOPLASMS *(cf. p. 173-194)*

MATURE T-CELL AND NK-CELL NEOPLASMS *(cf. p. 195-199)*

HODGKIN LYMPHOMA *(cf. p. 200-203)*

IMMUNODEFICIENCY-ASSOCIATED LYMPHOPROLIFERATIVE DISORDERS

[1] Former lymphoproliferative syndromes, malignant lymphomas

LYMPHOID NEOPLASMS (2)

PROOF OF MONOCLONALITY

Expression of one type only of light chain (κ or λ) on the lymphocyte surface (B)
Rearrangement of Ig genes (B)
Presence of paraprotein (B)
Rearrangement of TCR[1] genes (T)
Cytogenetics (B,T, NK)

CLINICAL CONDITION
PERFORMANCE STATUS OF THE EASTERN COOPERATIVE ONCOLOGY GROUP (ECOG)

GRADE	ECOG
0	Fully active, able to carry on all pre-disease performance without restriction
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature
2	Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about < 50% of waking hours
3	Only capable of limited selfcare, confined to bed or chair > 50% of waking hours
4	Completely disabled. Cannot carry on any selfcare.Totally confined to bed or chair

PROGNOSTIC FACTORS

Histology *(low grade → high grade)*
Staging
Tumor volume *("bulky disease")*
Performance status *(ECOG score)*
LDH serum level
Presence or not of inflammatory syndrome

CLINICAL BEHAVIOUR *(survival without treatment)*

Indolent	***years***
Aggressive	***months***
Highly aggressive	***weeks***

[1] TCR : T-Cell Receptor

LYMPHOID NEOPLASMS (3)
STAGING (ANN ARBOR CLASSIFICATION)

STAGES	EXTENSION
I	Involvement of single lymph node region
IE	Limited involvement of single extralymphatic organ or site
II	Involvement of two or more lymph node regions on the same side of the diaphragm alone
IIE	With involvement of limited contiguous extralymphatic organ or tissue
III	Involvement of lymph node regions on both sides of the diaphragm
IIIS	With spleen involvement
IIIE	With limited, contiguous extralymphatic organ or site
IIIES	With limited involvement of contiguous extralymphatic organ or site and spleen
IV	Diffuse involvement of one or more extranodal organ(s) or tissue(s) *(digestive tract, liver, lung, bone marrow, bone…)* with or without associated lymph node involvement

LYMPHOID NEOPLASMS (4)

INITIAL ASSESSMENT

Lymph node or tissue biopsy :

Histology, immunophenotyping, molecular biology, cytogenetics

Staging :

Clinical examination
Biological tests : ESR, CBC, LDH, electrolytes, creatinin, liver tests
CT-scan (if indicated PET-CT)
Bone marrow cytology and histology
(Spinal tap : CSF[1] examination)

Evaluation of prognosis :

Histological type *(low grade vs. high grade malignancy)*
IPI[2] score or aaIPI[3] *(aggressive lymphoid neoplasms)* : *1 pt. / criterion*
Age ≤ 60 years vs. > 60 years
Clinical condition *(ECOG[4] score)* 0 - **1 vs. ≥ 2**
Ann Arbor I-II vs. III-IV
Extranodal involvement 0-1 vs. > 1 site
LDH ≤ normal value vs. > normal level

Assessment of possible susceptibility :

History of immunosuppression (EBV)
Prior chemotherapy and / or radiotherapy
HIV, HTLV-1 serology

IPI SCORE	TX WITHOUT RITUXIMAB OVERALL SURVIVAL AT 5 YEARS (%)	TX WITH RITUXIMAB OVERALL SURVIVAL AT 3 YEARS (%)
0 - 1	73	91
2	51	81
3	43	65
4 - 5	26	59

aaIPI SCORE	≤ 60 YEARS OLD OVERALL SURVIVAL AT 5 YEARS (%)	> 60 YEARS OLD OVERALL SURVIVAL AT 5 YEARS (%)
0	83	56
1	69	44
2	46	37
3	32	21

Modified from Freedman A.S .& Friedberg J.V. : Evaluation, staging and prognosis of non-Hodgkin lymphoma.; October 2014, UpToDate.

Further tests :

Search for paraprotein, β_2-microglobulin, hepatitis B and C serology. ECG *(prior to chemotherapy)*

[1] CSF : Cerebrospinal fluid [2] IPI : International Prognostic Index [3] aaIPI : age adjusted IPI, 3 prognostic factors : ECOG + Ann Arbor + LDH

[4] ECOG : Eastern Cooperative Oncology Group

LYMPHOID NEOPLASMS (5)
TREATMENT

HIGHLY AGGRESSIVE LYMPHOID NEOPLASM *(e.g. Precursor B- or T-cell lymphoblastic leukemia / lymphoma)*

ALL type treatment : Prednisone - Vincristine - Anthracycline - Asparaginase - Methotrexate - Cytarabine ± Imatinib *(LLA Ph +)* **in various combinations** *(cf. p. 172)*
Intensification with autologous hematopoietic stem cell transplantation

± 25% overall survival at 5 years

AGGRESSIVE LYMPHOID NEOPLASM *(e.g. diffuse large B-cell lymphoma)*

CHOP[1], CHOP + Rituximab (anti-CD20)
Possible intensification with ACVBP[2], DA-EPOCH[3], CHOEP[4]

Overall 5 years survival *(dependent on IPI score)* ***about 30-40%*** *(cf. previous page)*

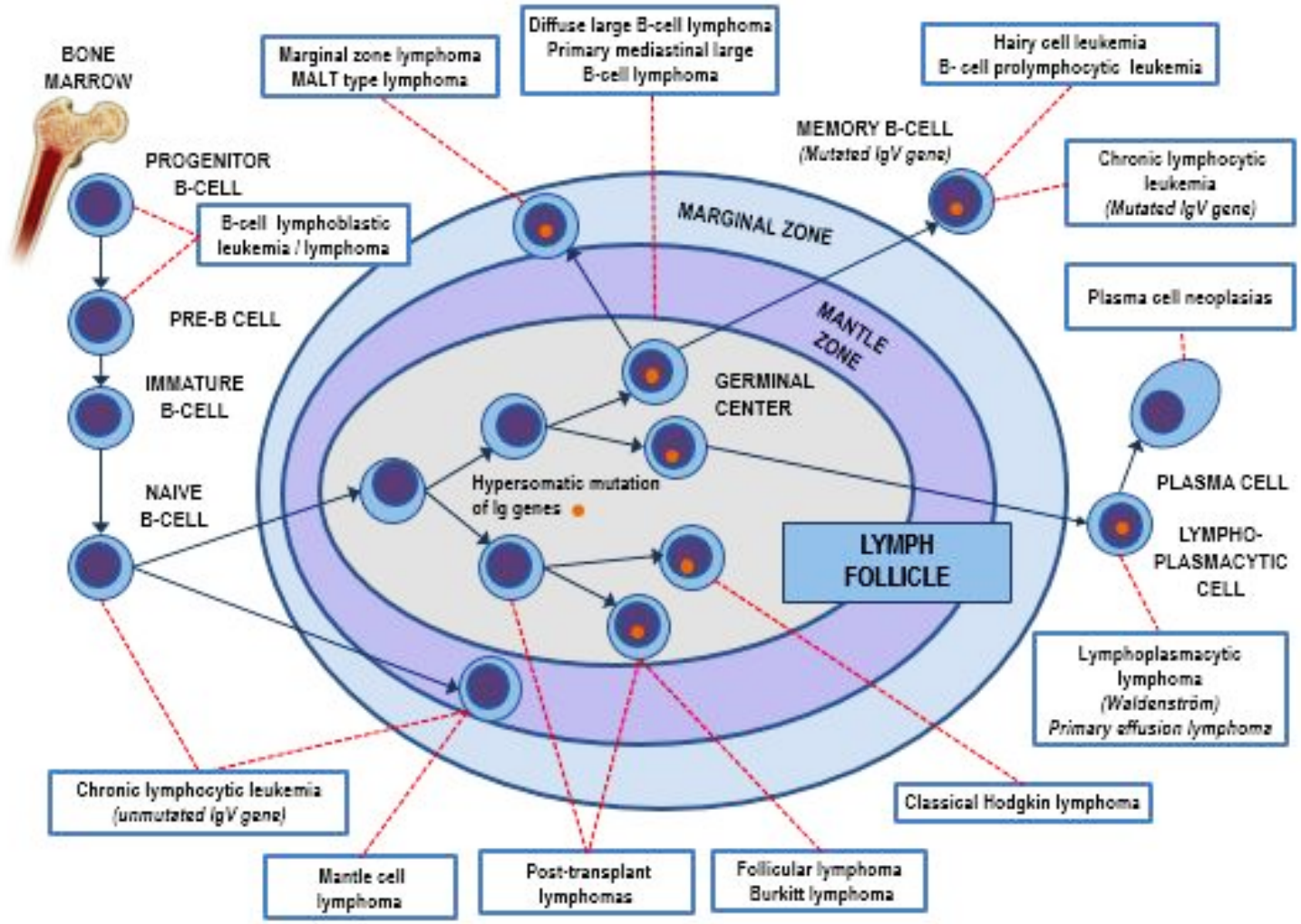
INDOLENT LYMPHOID NEOPLASM *(e.g. follicular lymphoma grade 1-2)*

Rituximab *(Mabthera®)* **alone or in combination, Cyclophosphamide, Bendamustine, Fludarabine, CVP[5], CHOP, FCR[6]**

Overall 5 years survival about 50-70%

[1] **CHOP :** Cyclophosphamide + Doxorubicine + Vincristine + Prednisone
[2] **ACVBP :** Doxorubicine + Cyclophosphamide + Vindesine + Bleomycin + Prednisone
[3] **DA-EPOCH :** Dose adjusted EPOCH : Etoposide + Prednisone + Vincristine + Cyclophosphamide + Doxorubicine
[4] **CHOEP :** Cyclophosphamide + Doxorubicine + Vincristine + Etoposide + Prednisone
[5] **CVP :** Cyclophosphamide + Vincristine + Prednisone
[6] **FCR :** Fludarabine + Cyclophosphamide + Rituximab

B-CELL DIFFERENTIATION
RELATIONSHIP TO MAJOR B-CELL NEOPLASMS



PRECURSOR B OR T-CELL LYMPHOID NEOPLASMS

LYMPHOBLASTIC LEUKEMIA / LYMPHOMA

B-cell lymphoblastic leukemia / lymphoma, NOS[1] (B-ALL / B-LL)

B-cell lymphoblastic leukemia / lymphoma with recurrent genetic anomalies

T-cell lymphoblastic leukemia / lymphoma

[1] NOS : Not Otherwise Specified

B-CELL LYMPHOBLASTIC LEUKEMIA / LYMPHOMA, NOS

B ACUTE LYMPHOBLASTIC LEUKEMIA (B-ALL)

Bone marrow usually involved, peripheral blood frequently

Extramedullary involvement

- Central nervous system
- Lymph nodes, spleen, liver
- Testes

Pancytopenia

Leukocyte count decreased, normal or very high

B LYMPHOBLASTIC LYMPHOMA (B-LBL)

Most frequent sites of involvement

- Skin
- Soft tissues
- Bone marrow
- Lymph nodes

B-CELL LYMPHOBLASTIC LEUKEMIA / LYMPHOMA
RECURRENT GENETIC ANOMALIES AND PROGNOSIS

UNFAVORABLE	INTERMEDIATE	FAVORABLE[1]
t(9;22)(q34;q11.2) : ***BCR-ABL 1***	t(1;19)(q23;p13.3) : ***TCF3-PBX1***	t(12;21)(p13;q22)[2] : ***ETV6-RUNX1***
t(v;11q23)[3]		
Hypodiploidy (< 46 chromosomes)		
Focal deletions / mutations of ***IF1KZ gene***[5]	t(5;14)(q31;q32) : ***IL3-IGH***	Hyperdiploidy[4] (51-65 chromosomes)
iAMP21[6]		
BCR-ABL-like ALL[7]		

[1] In absence of unfavorable prognostic factors *(âge > 10 years, initial hyperleucocytosis, slow response to first line treatment, minimal residual disease after initial treatment, CNS involvement at diagnosis and staging)*

[2] Frequent in children

[3] Commonest anomaly of precursor B-cell ALL of children < 1 year of age. Translocations implicate *KMT2A(MLL) gene in* 11q23 location and diverse partners thereof the most frequent is the *AFF1* gene, located on chromosome 4 in q21

[4] Frequent in children *(~ 25% of precursor B-cell ALL)*

[5] *IKZF1* : Ikaros Zinc finger 1. Translocation t(4;11) generates fusion gene *KMT2A-AFF1 IKZF1* (Ikaros Zinc Finger 1), located in 7p13; deletions of *IKZF1 gene* are observed in 10 to 17 % of precursor B-cell children ALL; they identify a subgroup of patients with unfavorable prognosis[8]

[6] Intrachromosomal amplification of chromosome 21, including *RUNX1 gene,* is observed in 2 to 5% of precursor B-cell children ALL. It is associated with unfavorable prognosis. Recent studies have shown that use of high risk type chemotherapy allows significant improvement of outcomre; it appears therefore that detecftion of iAMP at diagnosis is of major prognostic importance; this also underlines the need expressed by Harrisson CJ et al.[9] to recognize this subgroup of patients as a distinct WHO entity

[7] Group of precursor B-cell ALL identified on base of genic expression profile of leukemic cells, similar to what is observed in the *BCR-ABL 1 positive ALL,* but in absence of translocation t(9;22). This signature, observed in 10 à 25 % of children, adolescents and young adults is an unfavorable prognostic factor. In a recent study of a cohort of 1128 children with precursor B-cell ALL, *BCR-ABL 1* signature was shown to be an independant prognostic factor, as were the deletions of *IKZF1* (which are present in a large proportion *BCR-ABL 1*-like ALL). Introduction of *BCR-ABL 1*-like signature as high risk factor is being considered in various clinical protocols[8]

[8] *Van der Veer A. et al.: Independent prognostic value of BCR-ABL 1-like signature and IKZF1 deletion, but not high CRLF2 expression, in children with B-cell precursor ALL. Blood 2013; 122 : 2622-2629.*

[9] *Harrison CJ et al.: An international study of intrachromosomal amplification of chromosome 21 (iAMP21) : cytogenetic characterization and outcome. Leukemia 2014; 28 : 1015-1021.*

T-CELL LYMPHOBLASTIC LEUKEMIA / LYMPHOMA

Frequent mediastinal *(thymic)* **involvement**

Lymphadenopathies

Extranodal sites : skin, tonsils, liver, spleen, central nervous system, testes

High leukocyte count

High risk disease in childhood *(induction failure, early relapse, isolated CNS relapse)*

In adults, prognosis is better than for B-ALL with adverse prognostic cytogenetic anomalies

LYMPHOBLASTIC LEUKEMIA / LYMPHOMA

IMMUNOLOGICAL MARKERS

B-ALL :

PRO-B or EARLY PRE-B CD10 -

EARLY PRE-B or EARLY PRE-B CD10 + or COMMON PRE-B ALL

PRE-B

B MATURE (type Burkitt ALL) *(cf. p.185)*

MARKERS	PRO-B	EARLY PRE-B	PRE-B	B MATURE
CD19	+	+	+	+
CD10	-	+	+	-
CD20	-	+ / -	+	+
CD22	+ cyto	+	+	+
CD34	+ +	+	-	-
HLA-DR	+	+	+	+
TdT	+ + +	+ +	+	+ / -
cIgM[1]	-	-	+	
sIgM[2]	-	-	-	+

T-ALL :

PRE-T

EARLY-T

T CORTICAL

T MATURE OR MARROW T

MARKERS	PRE-T	EARLY-T	T CORTICAL	T MATURE
CD7	+	+	+	+
CD2	-	+	+	+
CD5	-	+	+	+
CD1a	-	-	+	-
cCD3[1]	+	+	-	-
CD3	-	-	+ / -	+
CD4 & CD8	-	-	+	-
CD4 or CD8	-	-	-	+
TdT	+	+	+	+

[1] cIgM, cCD3 : Intracytoplasmic IgM, CD3

[2] sIgM : IgM expressed on cell surface

TREATMENT OF LYMPHOBLASTIC LEUKEMIA / LYMPHOMA

CHEMOTHERAPY : **Prednisone, Vincristine, Anthracycline, Asparaginase, Methotrexate, Cytarabine en différentes combinaisons ± Imatinib** *(LLA Ph + voir tableau)*

PRINCIPLES : **Induction - Consolidation - Maintenance**

RESULTS :

Adults[1] (1991-2002) : **CR* : 64-93%**

DFS : 20-42%** *(at 5 years)*

Children : **CR* : 88-96%** *(2 children out of 3 cured at 5 years)*

ALL *BCR-ABL 1 +*	Chemotherapy alone (historical controls)[2]	Chemotherapy + Imatinib (%) (n = 45)[3]
Hematological CR*	71	96
Molecular CR*		29
Overall survival (at 18 months)	39	65
DFS** (at 18 months)	31	51

Followed, if possible, (age ≤ 55 years, related or unrelated donor) by bone marrow / stem cell transplantation in CR

***CR : Complete Remission**
****DFS : Disease Free Survival**

Developments of therapeutical possibilities :

Stratification for risk factors

Allograft in patients with unfavorable risk factors, early autologous transplantation with peripheral blood progenitor cells

Nucleosidic analogues *(Clofarabine, Nelarabine),* ***FMdC*** *(ribonucleotide reductase inhibitor),* ***Trimetrexate*** *(dihydrofolate reductase inhibitor),* ***liposomal Vincristine, Flavopiridol*** *[Cyclin-Dependent Kinase (CDK) inhibitor],* ***monoclonal antibodies*** *(anti-CD20, anti-CD52)*

Arsenic trioxide, proteasome or tyrosine kinase inhibitors[5]

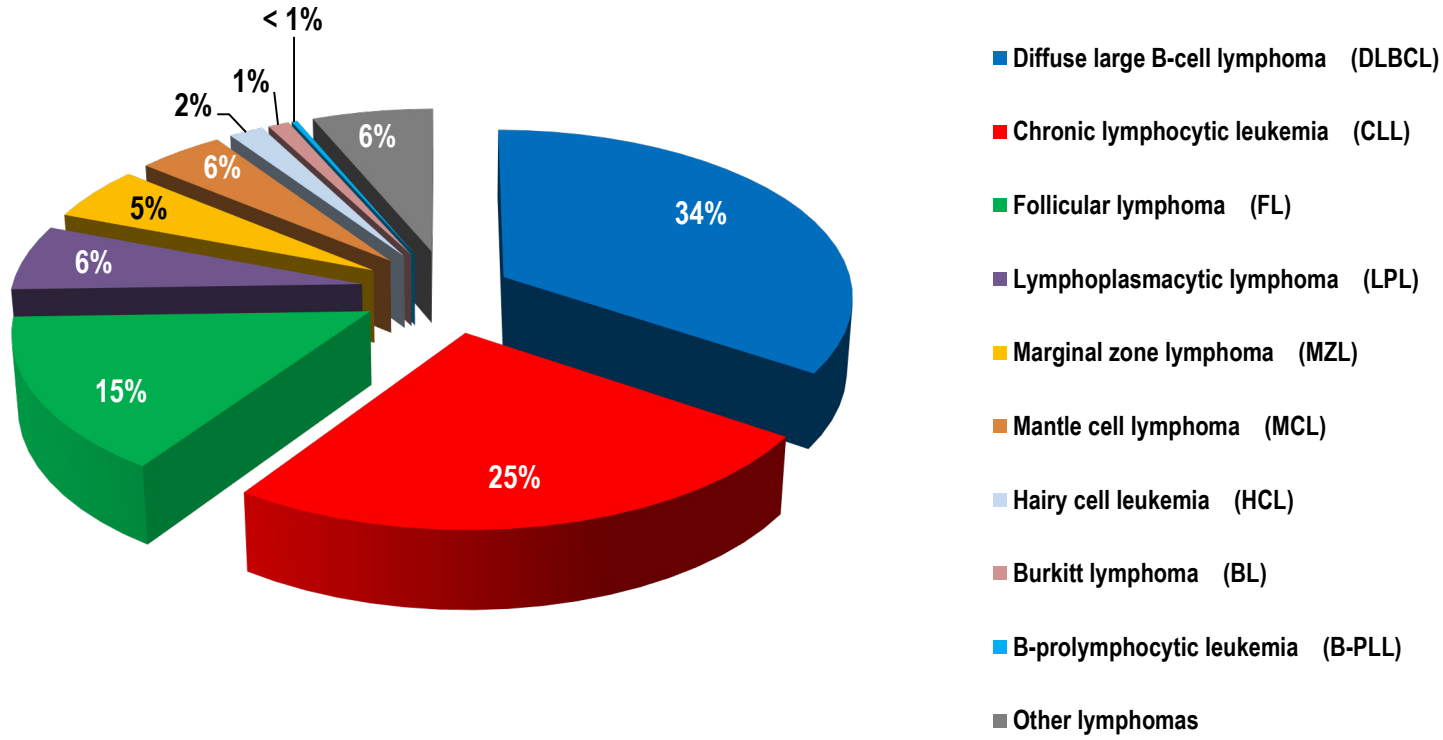
[1] *Hoelzer D., Gökbuget N. : Acute lymphocytic leukemia in adults, in Hoffman R. et al., Hematology : Basic Principles and Practice 2005; Elsevier : p. 1181.*

[2] *Larson R.A. : Induction therapy for Philadelphia chromosome positive acute lymphoblastic leukemia in adults; September 2014, UpToDate.*

[3] *Labarthe A. et al. : Imatinib combined with induction or consolidation chemotherapy in patients with de novo Philadelphia chromosome-positive acute lymphoblastic leukemia : results of the GRAAPH-2003 study. Blood 2007; 109 : 1408-1413.*

MATURE B-CELL LYMPHOID NEOPLASMS

RELATIVE FREQUENCY OF MATURE B-CELL LEUKEMIAS / LYMPHOMAS



Represent roughly 85% of lymphoid neoplasms (T / NK lymphoid neoplasms represent about 15%)

Plasmacytic myeloma is not included in this distribution of mature B cell leukemias / lymphomas. Its freqency is 10-15% of hematological neoplasms

After : Van de Schans S.A.M. et al. : Actual prognosis during follow-up of survivors of B-cell non-Hodgkin lymphoma in the Netherlands. Haematologica 2014; 99(2) : 339-345.

DIFFUSE LARGE B-CELL LYMPHOMA (DLCBL)

Epidemiology : ~ 30-40% of non-Hodgkin lymphomas, more common in males than in females, median age at diagnosis : 64 years

Features :
- Cervical lymph node bulk or abdominal mass with rapid growth
- B symptoms *(fever, sweats, weight loss)* in 30% of cases
- Stage I-II (~ 40%), III-IV (~ 60%) at initial presentation
- Extranodal and extramedullary involvement (> 40%) :
  - Digestive track *(stomach and ileocecal region)*
  - Bone, testis, breast, spleen, Waldeyer ring, salivary gland, thyroid, liver, kidney, adrenal, skin, bone marrow (11-27%)

Morphology : large cells, prominent nucleoli and basophilic cytoplasm
- Main variants : Centroblastic
- Immunoblastic
- Anaplastic

Molecular subgroups:
- Germinal Centre B-cell-like : GCB
- Activated B-cell-like : ABC

DLBCL subgroups :
1) T-cell / histiocyte rich DLBCL
2) Primary CNS DLBCL
3) Primary cutaneous leg type DLBCL
4) Chronic inflammation associated DLBCL

Prognosis : Depends on aaIPI *(age adjusted International Prognostic Index)* *(cf. p.164)*

Treatment :
- Initial : CHOP *(cf. p.165)* + Rituximab (R), R-ACVBP[1] or DA-EPOCH[2] + R
- Chemotherapy + radiotherapy *("Bulky disease")*
- Intrathecal chemotherapy

Refractoriness or relapse : R-ICE[3] or DHAP[4] followed by autologous stem cell transplant

Immunophenotype :

sIg (50-75%) : sIgM > sIgG > sIgA, CD19 +, CD20 +, CD22 +, cCD79a +, CD45 +,
CD10 + (30-60%), CD5 - (10% +)

Immunohistochemistry :

Expression de BCL2 + (25-80%), BCL6 + (~ 70%), Ki67 + *(proliferation index)* : > 40%

Cytogenetics :

Anomalies in 3q27 [more than 20 different translocations with rearrangement of gene *BCL6* (20-40%)]
Abnormal overexpression of *BCL6*

t(14;18)(q32;q21) with rearrangement *IGH / BCL2* (20-30% of cases); t(8;14)(q24;q32) or variants t(2;8)(p12;q24) et t(8;22)(q24;q11) (~10%) with rearrangements *MYC / IGH, MYC / IGK* or *MYC / IGL* respectively

[1] ACVBP : Adriamycine + Cyclophosphamide + Vincristine + Bleomycin + Prednisone
[2] DA-EPOCH : Dose Adjusted Etoposide + Prednisone + Vincristine + Cyclophosphamide + Adriamycine
[3] R-ICE : Rituximab + Ifosfamide + Carboplatin + Etoposide
[4] DHAP : Dexamethasone + Adriamycine + Cisplatine

CHRONIC LYMPHOCYTIC LEUKEMIA (CLL)

DEFINITION

Monoclonal B-cell lymphoid proliferation

SYMPTOMS AND CLINICAL FEATURES

Fortuitous diagnosis
Lymph node enlargement
Splenomegaly
Relapsing infections
Severe anemic syndrome
Hemorrhagic manifestations

BLOOD PICTURE

Relative and absolute lymphocytosis
Monoclonality shown by cell surface markers :
- Coexpression of CD5 / CD19
- κ or λ expression
- CD 200 +

CLASSIFICATION *(cf. next page)*

Rai
Binet

CHRONIC LYMPHOCYTIC LEUKEMIA (2)

RAI CLASSIFICATION (1975)

STAGE	CRITERIA	MEDIAN SURVIVAL (MONTHS)
0	Isolated monoclonal lymphocytosis *(peripheral blood and bone marrow)*	150
I	0 + lymphadenopathies[1]	101
II	0 and I + splenomegaly[2] and / or hepatomegaly[2]	71
III	0 and Hb < 100 g / L ± tumoral syndrome	19
IV	0 and platelets < 100 G / L ± tumoral syndrome	19

BINET CLASSIFICATION (1981)

STAGE	LYMPHOID SITES[3]	Hb AND PLATELETS	MEDIAN SURVIVAL (MONTHS)
A	< 3	Hb ≥ 100 g / L Platelets ≥ 100 G / L	Comparable to age-matched control
B	≥ 3		84
C	Irrelevant	Hb < 100 g / L or Platelets < 100 G / L	24

[1] Cervical, axillary, inguinal lymph nodes on clinical examination
[2] On abdominal palpation
[3] Cervical, axillary, inguinal lymph nodes, splenomegaly and hepatomegaly on clinical examination

Rai K.R., Keating M.J. : Staging and prognosis of chronic lymphocytic leukemia; November 2014, UpToDate.

CHRONIC LYMPHOCYTIC LEUKEMIA (3)

COURSE AND COMPLICATIONS

Infection secondary to :

B-cell immunological defect
Potential neutropenia *(mainly secondary to chemotherapy)*

Autoimmune manifestation[1]

Hemolytic anemia with positive direct Coombs test *(advanced stage : 11%)*
Immune thrombocytopenia *(early stage : 2-3%)*
Pure red cell aplasia / Erythroblastopenia *(early stage : 6%)*

Prolymphocytoid transformation (~ 10%)

Transformation to diffuse large B-cell lymphoma (DLBCL) : Richter syndrome (1-10%)

⇗ risk of developing another neoplasm : bone, skin, thyroid, ENT region, lung

DIFFERENTIAL DIAGNOSIS

Viral or bacterial lymphocytosis *(cf. p.113)*

Other lymphoid neoplasm

[1] *Diehl L.F., Ketchum L.H.: Autoimmune disease and chronic lymphocytic leukemia : autoimmune hemolytic anemia, pure red cell aplasia, and autoimmune thrombocytopenia. Semin Oncol 1998; 25 : 80-97.*

CHRONIC LYMPHOCYTIC LEUKEMIA (4)
PROGNOSTIC FACTORS

PARAMETER	FAVORABLE	UNFAVORABLE
Rai or Binet stages	Low	High
Bone marrow lymphocytic infiltration	Nodular or interstitial	Diffuse
Peripheral lymphocytosis doubling time	> 12 months	< 12 months
Immunophenotyping	CD38 -, (ZAP-70)[1]	CD38 +, (ZAP 70 +), ⇗ CD20, ⇗ CD52
Conventional cytogenetics, FISH, molecular genetics	Normal karyotype Del(13)(q14.3) isolated	Del(11)(q22.3) Del(17)(p13.1) / *TP53* mutation
IgV genes *(variable region of immunoglobulins)*	Mutated	Unmutated
Others		Dysfunction or ⇗ of p53 expression ⇗ TNF-α, β_2-microglobulin, IL-6, 8, 10, LDH, VEGFR-2[2]

[1] ZAP-70 : Zeta chain-Associated Protein : tyrosine kinase restricted to T- and NK-lymphocytes under normal physiological conditions (questionable utility)
[2] Vascular Endothelial Growth Factor Receptor-2

Modified from Rai K.R., Keating M.J. : Staging and prognosis of chronic lymphocytic leukemia; November 2014, UpToDate.

CHRONIC LYMPHOCYTIC LEUKEMIA (5)
TREATMENT

First line treatment

"Wait and watch" as long as possible

Alkylating agents : *Chlorambucil ± Rituximab (anti-CD20), Bendamustine ± Rituximab*

Purine analogues : *Fludarabine, Cladribine*

Polychemotherapy : *Cyclophosphamide + Fludarabine + Rituximab*

Steroids *(in case of autoimmune hemolytic anemia)*

Polyvalent immunoglobulin concentrates *(in case of relapsing infections related to B immunological defect)*

Refractory disease or relapse treatment

Alemtuzumab : humanized anti-CD52 (MabCampath)

Ofatumumab : humanized anti-CD20 (increased affinity for CD20)

I**brutinib :** *(inhibitor of Bruton's tyrosine kinase)*

Idealisib : *(inhibitor of phosphoinositide 3-kinase)* + **Rituximab**

Stem cell (bone marrow) transplantation
[young patients, aggressive disease, presence of del (11)(q22.3) or del (17(p13.1)]

FOLLICULAR LYMPHOMA (FL)

~ 15 % of non Hodgkin lymphomas, median age : 60 years, sex ratio 1 : 1.7

Origin : Centrocytes and centroblasts from the germinal center of the lymph follicle

Histology : Follicular architecture with centrocytes *(cells of small to medium size with cleft nuclei)* and centroblasts

Aggressiveness dependent on the proportion of centroblasts :
1) grade I : 0-5 centroblasts / microscopic field
2) grade II : 6-15 centroblasts / microscopic field
3) grade III : > 15 centroblasts / microscopic field *(magnification : 40x)*

Localisations : Peripheral lymphadenopathies, hilar, mediastinal, spleen (40%), liver (50%), bone marrow (60-70%)
Tumor bulks of the digestive tract, urinary tract, epidural, with symptoms or not

B symptoms in 20% of cases : fever, sweats, weight loss

Immunophenotype :

sIg + (IgM : 50-60%, IgG : 40%), CD19 +, CD20 +, cCD79a +, CD10 + (60%), CD5 -, CD11c - CD23 - / +, CD43 -

Cytogenetics :

t(14;18)(q32;q21) (~ 85% of cases) or variants t(2;18)(p12;q21) and t(18;22)(q21;q11) (very rare) with rearrangement *IGH / BCL2*, *IGK / BCL2* or *IGL / BCL2* respectively anomalies in 3q27 [t(3q27)] with rearrangement of *BCL6* gene (more frequent in grade III : aggressive follicular lymphomas)

Molecular biology :

BCL2-JH fusion detected by PCR (except rare breakpoints of *BCL2* gene)

Prognosis : depends on the FLIPI (Follicular Lymphoma International Prognostic Index)

Risk factors (1 point / factor) :

Age > 60 years
⇗ LDH
Hb < 120 g / L
Ann Arbor stages III-IV
lymphatic sites > 4

Score	Risk groups	Survival rate at 5 years (%)	Survival rate at 10 years (%)
0-1	Low	91	71
2	Intermediate	78	51
3-5	High	52	36

FLIPI calculator : http://www.qxmd.com/calculate-online

Treatment : Localized, asymptomatic type : "wait and watch"
Localized and symptomatic type : radiotherapy, possibly surgical excision
Aggressive type : Rituximab, Bendamustine, CVP or CHOP *(cf. p.165)* + Rituximab, Fludarabine + Rituximab
Radio-immunoconjugate anti CD20 (Ibritumomab, Ositumomab), elderly or fragile patients
Allogeneic transplant (young patient with HLA identical donor)

[1] *Modified from Solal-Céligny P., Roy P., Colombat P. et al. : Follicular Lymphoma International Prognostic Index. Blood 2004; 104 : 1258-1265.*

LYMPHOPLASMACYTIC LYMPHOMA (LPL)
WALDENSTRÖM MACROGLOBULINEMIA (WM)

Lymphoplasmacytic bone marrow infiltration

Splenomegaly, hepatomegaly and / or adenopathy in 15-30% of patients

Peripheral blood may be involved : mixture of small and large lymphocytes, sometimes with eccentric nucleus and pronounced cytoplasmic basophilia

Mainly IgM paraproteinemia (WM) : hyperviscosity syndrome (IgM > 30 g / L)

Possible cryoglobulinemia (~ 10%) *(Raynaud phenomenon, vasculitis)*

Anemia of variable severity
- **Hemodilution**
- **Bone marrow failure**
- **Autoimmune hemolytic anemia** *(cold agglutinins)*

Polyneuropathy with sensory and motor defect
(anti-MAG[1] antibodies)

Bleeding tendency *(thrombocytopenia + thrombopathy)*

Indolent lymphoid neoplasm

Immunophenotype :

sIgM +, CD5 - / +, CD10 -, CD19 +, CD20 +, CD23 -, CD103 - , plasmacytic component : CD138 +

Molecular biology :

MYD88 LPL265P mutation (80-90% des cas)

Differential diagnosis : **IgM MGUS[2]** *(IgM < 30 g / L, no anemia, hepatosplenomegaly, adenopathies nor general symptoms; bone marrow lymphoplasmacytic cells < 10%)*

Treatment :
- **Plasmapheresis if hyperviscosity syndrome**
- **Rituximab alone or combined with purine analogues** *(Fludarabine, Cladribine)*
- **Cyclophosphamide-Rituximab, corticosteroids**
- **Bortezomib + Rituximab**

Median survival : **5-10 years**

[1] Myelin Associated Glycoprotein
[2] MGUS : Monoclonal Gammapathy of Unknown Significance

SPLENIC B-CELL MARGINAL ZONE LYMPHOMA (SMZL)

Splenomegaly
Variable presence in peripheral blood of villous lymphocytes
Occasionally autoimmune thrombocytopenia or anemia
Small monoclonal serum paraprotein *(1/3 of cases)*
Clinical course indolent
Treatment : splenectomy

Immunophenotype :

CD20 +, cCD79a +, CD5 -, CD25 + / -, CD11c + / -, CD103 -, CD123 - (~ 3% of cases +)

SPLENIC B-CELL LEUKEMIA / LYMPHOMA, UNCLASSIFIABLE

Splenic diffuse red pulp small B-cell lymphoma

Frequently massive splenomegaly
Usually low lymphocytosis, presence of villous lymphocytes
Sometimes cutaneous infiltration *(pruritic papules)*
Indolent lymphoma, not curable; beneficial effect of splenectomy

Immunophenotype :

CD20 +, CD25 -, CD5 -, CD103 -, CD123 -, CD11c -, CD10 -, CD23 -, IgG +, IgD -

Immunohistochemistry :

Annexin A1 -

Hairy cell leukemia-variant *(cf. p. 184)* *- "Prolymphocytic variant"*

Average WBC count ~ 35 G / L, ↘ platelets (~ 50%), ↘ RBC (~ 25%)
Lymphocytes : hybrid features of prolymphocytic leukemia and classical hairy cell leukemia
Absence of monocytopenia

Treatment : Rituximab

Usually no response to purine analogues and to α-Interferon

Immunophenotype :

Identical to classical form apart from : CD25 -, CD123 - / +

Cytochemistry :

TRAP negative or weakly +

MANTLE CELL LYMPHOMA (MCL)

~ 6% of non Hodgkin lymphomas, median age : 68 years, sex ratio : 3:1

Origin : Naïve B Lymphocytes of the mantle zone of lymphatic follicle

Histology : 1) Small cleaved cells, centrocytic type
2) blastoid aggressive variant
3) pleiomorphic aggressive variant

Localizations : Lymphadenopathies, splenomegaly (40-60%), bone marrow (> 60%), peripheral blood, digestive track, Waldeyer ring

B symptoms in > 1/3 of cases : fever, sweats, weight loss

Prognosis : based on IPI *(cf. page 164) or*
MPI (Mantle Cell Lymphoma International Prognostic Index)[1,2]

Immunophenotype :

sIgM ± IgD, λ light chains, CD19 +, CD20 +, CD5 + (rarely -), CD43 +, FMC-7 +, CD10 -, BCL6 -, CD23 - (or weakly +), CD200 -

Immunohistochemistry :

Cyclin D1 (BCL1) + (> 90%)

Genetics and molecular biology :

t(11;14)(q13;q32) with rearrangement of *CCND1(BCL1) / IGH (abnormal overexpression of Cyclin D1)* : 50-65% by conventional cytogenetics, ~ 100 % by FISH
BCL1 / JH fusion detected by classical PCR techniques only in ~ 40% of cases

Prognostic criteria

Points	Age (years)	Performance index	LDH *	Leukocytes (G / L)
0	< 50	0-1	< 0.67	< 6.7
1	50-59		0.67-0.99	6.7-9.9
2	60-69	2-4	1.00-1.49	10.0-14.9
3	≥ 70		> 1.50	> 15

* Ratio of upper range level

Prognosis

Score (points)	Risk group	Median survival (months)	5 years survival (%)
0-3	Low	Not reached	60
4-5	Intermediate	58	35
6-12	High	37	20

[1] *Hoster E. et al.: A new prognostic index (MPI) for patients with advanced-stage mantle cell lymphoma . Blood 2008; 111 : 558-565.*
[2] *Hoster E et al. : Erratum. Blood 2008; 111 : 576.*

MIPI calculator :
www.european-mclnet/en/clinical_mipi.php

Treatment :

Indolent type *(absence of tumor bulk or general symptoms)* **:** "wait and watch". If treatment necessary :

Patient < 65 ans : alternating R-CHOP and R-DHAP, followed by intensive chemotherapy (i.e. BEAM) with autologous stem cell transplantation

Patient > 65 ans : R-CHOP or association with a purine analogue or Rituximab-Bendamustine
Maintenance with Rituximab

HAIRY CELL LEUKEMIA (HCL)

Splenomegaly without lymphadenopathies

Pancytopenia

Leukocytes usually < 4 G / L, > 10 G / L (10-20%), exceptionally > 200 G / L, monocytopenia

Presence of tricholeukocytes, TRAP + *(Tartrate Resistant Alkaline Phosphatase)*

Bone marrow fibrosis

Complications : **Recurrent infections**
Vasculitis or other immune disease
Neurological disorders
Bleeding occurrence
Bone lesions

Treatment : **Purine analogues *(Cladribine)***
Rituximab in relapse

Overall survival at 10 years : > 90%

Immunophenotype :

CD19 +, CD11c +, CD22 +, CD25 +, CD103 +, CD123 +

Immunohistochemistry :

Annexin A1 +, Cyclin D1 ±

B-CELL PROLYMPHOCYTIC LEUKEMIA (B-PLL)

Large splenomegaly, few or absent lymphadenopathies

Lymphocytosis > 100 G / L, anemia and thrombocytopenia (50% of cases)

Large cells with prominent nucleolus :

Treatment : **CHOP** *(cf. p.165)***, purine analogues** *(fludarabine, cladribine),* **chemotherapy + Rituximab, splenectomy**

Median survival : 30-50 months

Immunophenotype :

CD19 +, CD20 +, CD22 +, CD23 + (10-20%), cCD79a +, CD79b +, FMC-7 +, CD5 + (20-30%)

Cytogenetics :

del 17p, mutation TP53 (~ 50%), del 13q14 (~ 25%)
(very few described cases)

BURKITT LYMPHOMA (BL)

Types : **1) Endemic (Africa); 2) Sporadic; 3) Linked to AIDS**

Association : **To EBV** *(Epstein-Barr Virus)*, **mostly in endemic type**

Localization : **Frequent involvement of central nervous system in all 3 types**
Involvement of jaw and other facial bones in the endemic type
Abdominal involvement *(ileocecal region)*, **ovaries, kidneys, breasts in the sporadic type**
Lymphadenopathies and bone marrow involvement in AIDS linked type

Rapidly progressive, frequently bulky : large abdominal tumor masses

Treatment : **R-CODOX-M[1] / IVAC[2] + intrathecal Methotrexate**
DA-EPOCH[3] + Rituximab *(patients > 60 years)*

Immunophenotype :
sIgM +, CD19 +, CD20 +, CD22 +, CD10 +, BCL6 +, CD38 +, CD77 +,CD43 +, BCL2 + / - (20%), TdT -, Ki67 +

Genetics and molecular biology :

t(8 ;14)(q24;q32) *(75-85% of cases),* or variants t(2;8)(p12;q24) and t(8;22)(q24;q11) [*15-25% of cases*], t(8;22) more frequent than t(2;8) with M*YC / IGH, MYC / IGK MYC / IGL re*arrangements respectively

Deregulation of MYC oncogene by translocation of MYC gene with "enhancer" elements of genes coding for heavy or light immunoglobulin chains

Rearrangements of immunoglobulins genes; mutations of *BCL6* gene (25-50% of cases)

Variant type : **Acute lymphoblastic leukemia Burkitt type**

Blood and bone marrow involvement
Blast cells with hyperbasophilic cytoplasm with vacuoles
Frequent involvement of CNS at diagnosis
Treatment : *(cf. p.172)* *(treatment of lymphoblastic leukemia / lymphoma)*
Extreme chemosensitivity *(risk of acute tumor lysis syndrome)*

[1] **R-CODOX-M :** **Cyclophosphamide + Vincristine + Doxorubicin + Methotrexate high dose + Rituximab (R)**
[2] **IVAC :** **Ifosfamide + Cytarabine + Etoposide**
[3] **DA- EPOCH :** **Dose Adjusted Etoposide + Vincristine + Doxorubicin + Cyclophosphamide + Prednisone**

PLASMA CELL NEOPLASMS

Clonal expansion of mature B cells, after isotypic switch of heavy chains, secreting a homogeneous immunoglobulin (= paraprotein)
Occasional biclonality

Presence of paraprotein is also called monoclonal gammopathy

1) IgG, IgA and light chains gammopathies :
Plasma cell neoplasms

2) IgM and heavy chains gammopathies :
- ***a) Lymphoplasmacytic lymphoma (Waldenström macroglobulinemia)***
(cf. p.181)

- ***b) Heavy chain deposition diseases***

	HISTOLOGY	CLINICAL SITES
γ heavy chain disease	Lymphoplasmacytic lymphoma	Lymph nodes, Waldeyer ring, bone marrow, spleen, liver, blood
μ heavy chain disease	Chronic lymphoid leukemia	Spleen, liver, bone marrow, blood
α heavy chain disease (IPSID)[1]	Extranodal marginal zone lymphoma of mucosa associated lymphoid tissue (MALT)[2]	Small bowel, mesenteric lymph nodes

[1] IPSID : Immunoproliferative Small Intestinal Disease
[2] MALT : Mucosa-Associated Lymphoid Tissue

WHO CLASSIFICATION 2008

Monoclonal gammopathy of undetermined significance / MGUS

Plasma cell myeloma
- Asymptomatic ("smoldering") plasma cell myeloma
- Symptomatic plasma cell myeloma
- Non secretory plasma cell myeloma
- *Plasma cell leukemia*

Plasmacytoma
- *Solitary plasmacytoma of bone*
- *Extraosseous (extramedullary) plasmacytoma*

Immunoglobulin deposition diseases
- *Primary amyloidosis*
- *Systemic light and heavy chain deposition diseases*

Osteosclerotic myeloma (POEMS) :
- *P*olyneuropathy
- *O*rganomegaly : spleen, liver, lymph nodes
- *E*ndocrinopathy : diabetes, gynecomastia, testicular atrophy
- *M*-component : monoclonal gammopathy
- *S*kin : hyperpigmentation, hypertrichosis

In italics : disorders not developed in the synopis

PLASMA CELL NEOPLASMS
DIAGNOSIS

Paraprotein pattern :

Protein electrophoresis, immunofixation, quantitative immunoglobulins dosage (serum)
Free light chains (FLC), κ / λ ratio (serum)
Protein electrophoresis, immunofixation (urine)[1]
Dosage of light chains (Bence Jones proteins) in 24h urine collection

Peripheral blood examination :

(inclusive platelets, reticulocytes and microscopic blood smear examination / RBC rouleaux formation)

Blood chemistry :

Creatinin, Calcium, Albumin, LDH, β_2-microglobulin, CRP, alkaline phosphatase, ALAT, ASAT

Bone marrow examination :

Cytology and histology, immunophenotyping, cytogenetics and FISH[2]

Radiology work-up :

Conventional Xray examination : spine, skull, pelvis and long bones, ± CT / IRM (whole body) / PET-CT (Bone scintigram poorly reliable)

TYPES OF PARAPROTEINS[1] / FREQUENCY

TYPE	%	TYPE	%
IgG	50	IgD, IgM, biclonal	<10
IgA	20	Absence of paraprotein	~3
Light chains	20	IgE	<1

[1] PARAPROTEIN = MONOCLONAL IMMUNOGLOBULIN

[1] FISH : Fluorescent In Situ Hybridization

PLASMA CELL NEOPLASMS
FREE SERUM LIGHT CHAINS (FLC) AND κ / λ FLC RATIO

Immunonephelometric measurement of free kappa (κ) or lambda (λ) monoclonal light chains in serum (FLC) is of diagnostic, prognostic and monitoring relevance

The result can also be expressed as the ratio of κ to λ free light chains amounts

Reference range :

FLC κ : 3.3 – 19.4 mg / L
FLC λ : 5.7 – 26.3 mg / L
κ / λ ratio : 0.26 – 1.65

Examples :

- FLC κ : **9.6 mg / L** FLC λ **: 16.5 mg / L**
  κ / λ ratio : **9.6 / 16.5 = 0.58** *(normal)*

- FLC κ : **2.5 mg / L** FLC λ : **32.8 mg / L**
  κ / λ ratio : **2.5 / 32.8 = 0.076** *(< 0.26)*[1]

- FLC κ : **28.0 mg / L** FLC λ **: 6.25 mg / L**
  κ / λ ratio : **28.0 / 6.24 = 4.48** *(> 1.65)*[2]

[1] Low abnormal by excess of λ FLC

[2] High abnormal by excess of κ FLC

INDICATIONS TO FLC AND κ / λ RATIO MEASUREMENT

Diagnostic parameter of non secretory (or low secretory) plasma cell myeloma

Complementary diagnostic parameter of plasma cell myeloma with complete paraprotein

Risk parameter for MGUS evolution to plasma cell myeloma

Risk parameter for smoldering plasma cell myeloma to symptomatic myeloma

Risk parameter for progression of solitary plasmacytoma

Prognostic parameter (independent risk factor) for plasma cell myeloma

Monitoring parameter during and after treatment of plasma cell myeloma :

Indicator of early treatment response

Indicator of response quality (normalization of values allows the definition of a «stringent» complete remission)

Early indicator of relapse

Modified from : Dispenzieri A. & al. International Myeloma Working Group guidelines for serum free light chain analysis in multiple myeloma and related disorders. Leukemia 2009; 23 : 215-224.

MGUS AND PLASMA CELL MYELOMA
DIFFERENTIAL DIAGNOSIS / COURSE

DIFFERENTIAL DIAGNOSIS OF MGUS, SMOLDERING AND SYMPTOMATIC PLASMA CELL MYELOMA

	MGUS	SMOLDERING MYELOMA	SYMPTOMATIC MYELOMA
Plasma cells *(Bone marrow)*	**< 10%**	**≥ 10%**	**> 10%[1]**
Monoclonal immunoglobulin (Ig)	**< 30 g / L** **⇘ other Ig : 30-40% of cases** **FLC[2] no / slight ⇗**	**> 30 g / L** **⇘ other Ig : > 90% of cases** **FLC[2] ⇗. κ / λ ratio abnormal**	**Monoclonal Ig +** **⇘ other Ig usual** **FLC[2] ⇗ ⇗. κ / λ ratio abnormal**
CRAB[3]	**0[4]**	**0[4]**	**CRAB[3] + / ++**

[1] Clonal plasmocytosis > 60% or pathological light chain / normal chain ratio > 100 or > 1 bone lesion on MRI is a sufficient diagnostic criterion
[2] FLC : Free Light Chains in serum. κ / λ ratio : free κ and λ light chains level ratio or pathological FLC / normal FLC ratio
[3] CRAB (related organ involvement) : Hypercalcemia > 2.75 mmol / L (C). Renal failure : creatinin > 177 µmol / L / clearance < 40 ml / min (R)
Anemia : Hb < 100 g / L or < 20 g / L of RI (A). Lytic bone lesion : 1 or more lesion(s) on skeleton X-ray or CT-scan or PET-CT (B)
(If medullary plasmocytosis < 10% > 1 lytic bone lesion requested)

[4] And absence of amyloidosis

After : Rajkumar S.V. : Clinical features, laboratory manifestations, and diagnosis of multiple myeloma;. March 2015, UpToDate.

The measurement of FLC and κ / λ ratio ist a key parameter for the follow-up of MGUS or indolent plasma cell myeloma. It is a reliable, independent risk factor

Initial measurement allows to define a patient **group with excellent prognosis** for whom follow-up may be done at large intervals *(e.g. yearly)*

RISK OF MGUS OR SMOLDERING MYELOMA PROGRESSION RELATION TO κ / λ RATIO

	PROGNOSTIC CRITERIA	RISK OF PROGRESSION	% PATIENTS
MGUS 3 - 5 % of patients > 70 years	**normal κ / λ ratio[1]** **paraprotein < 15 g / L** **IgG type**	**< 5% at 30 years**	**± 40%**
	κ / λ ratio 0.25 – 4.0	**± 20% at 30 years**	**± 60%[2]**
	κ / λ ratio < 0.25 / > 4.0	**± 45% at 30 years**	**± 30%**
SMOLDERING MYELOMA	**κ / λ ratio 0.125 – 8.0**	**± 50% at 15 years**	-
	κ / λ ratio < 0.125 ou > 8.0	**± 80% at 15 years**	-

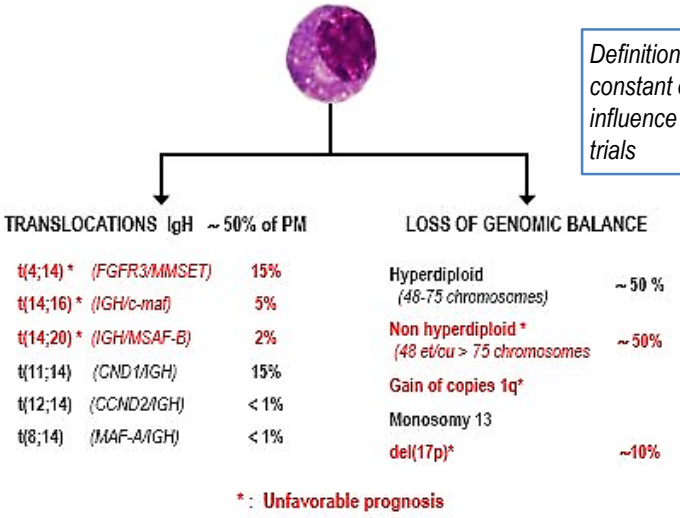
[1] Normal κ / λ ratio : 0.26 –1.65

[2] Including the 40% of excellent prognosis

PLASMA CELL MYELOMA
PROGNOSTIC FACTORS

Paraprotein serum level : IgG or IgA
Type of paraprotein : IgA unfavorable
Level of serum free light chains and κ / λ ratio
β_2- microglobulin level *(serum)*
Hypercalcemia (C)
Renal failure (R)
Anemia ≤ 100 g / L (A)
Bone lesion(s) (B)
C R A B
Bone marrow infiltration > 50%
Performance index ≥ 3

Cytogenetics (or FISH) of bone marrow plasmocytes[1]



Definitions of risk factors are in constant evolution under the influence of clinical therapeutical trials

Genomics : *GEP[2] "high risk signature"*

[1] *After : Chesi M., Bergsagel P.L. : Molecular pathogenesis of multiple myeloma: basic and clinical updates. Int J Hematol. 2013; 97 : 313-323.*

[2] Gene Expression Profile

DURIE & SALMON STAGES

STAGE	DESCRIPTION
I	**Low tumor mass** *All following criteria* Hemoglobin > 100 g / L IgG serum < 50 g / L or IgA serum < 30 g / L Normal calcemia Urine paraprotein < 4 g / day No generalized bone lesions
II	**Values intermediate between I and III**
III	**High tumor mass** *One or more following criteria* Hemoglobin < 85 g / L IgG serum >70 g / L or IgA serum > 50 g / L Calcemia > 3 mMol / L Urine paraprotein > 12 g / day
A	Creatinin (serum) < 170 µMol / L
B	Creatinin (serum) > 170 µMol / L

PLASMA CELL MYELOMA
PROGNOSTIC FACTORS (2)

ISS (International Staging System) : 8'449 patients[1]

STAGE	PARAMETERS	MEDIAN SURVIVAL (MONTHS)
1	β_2-m[2] < 3.5 mg / L Albumin ≥ 35 g / L	62
2	β_2-m[2] < 3.5 mg / L Albumin < 35 g / L ou β_2-m[1] ≥ 3.5 - < 5.5 mg / L	44
3	β_2-m[2] ≥ 5.5 mg / L	29

[1] Modified from : Greipp P.R. et al. : International staging system for multiple myeloma. J Clin Oncol 2005; 23 : 3412-3420.

[2] β_2-m : β_2-microglobulin

MEDIAN OVERALL SURVIVAL RELATED TO GENETICS OR GENOMICS

< 3 YEARS	4 - 5 YEARS	8 - 10 YEARS
HIGH RISK	**INTERMEDIATE RISK**	**STANDARD RISK**
GENETICS ▪ del 17p ▪ t(14;16) ▪ t(14;20) GENOMICS : ▪ "high risk" signature	GENETICS ▪ t(4;14)* ▪ del(13q)** ▪ hypodiploidy * *intermediate risk because of the efficacy of first line Bortezombib based therapy in presence of this anomaly* ** *if detected by conventional karyotyping*	All other anomalies namely : ▪ Trisomies (hyperdiploidy)* ▪ t(11;14) ▪ t(6;14) * *Presence of trisomy cancels the impact of associated high risk anomalies.*

[1] *After : Chesi M., Bergsagel P.L. : Molecular pathogenesis of multiple myeloma: basic and clinical updates. Int J Hematol. 2013; 97 : 313-323.*

Prognostic impact of κ / λ ratio[3] on ISS

RISK GROUP	1 YEAR SURVIVAL %	5 YEARS SURVIVAL %	MEDIAN SURVIVAL (MONTHS)
ISS Stage I			
κ / λ ratio 0.03 - 32	87.6	41.5	51
κ / λ ratio < 0.03 / > 32	88.9	29.8	41
ISS Stage II			
κ / λ ratio 0.03 - 32	83.2	35.2	40
κ / λ ratio < 0.03 / > 32	77.5	20.5	30
ISS Stage III			
κ / λ ratio 0.03 - 32	67.6	24.4	17
κ / λ ratio < 0.03 / > 32	62.5	15.3	23

[3] κ / λ ratio of serum Free Light Chains (FLC)

Modified from Snozek C.L.H., Katzmann J.A., Kyle R.A. & al. Leukemia 2008; 22 : 1933–1937.

COMPLICATIONS

Hyperviscosity syndrome (mostly IgA, IgG3)

Neurologic : **compression (spinal or radicular)**

Renal : **light chain, calcic or uric nephropathy, amyloidosis, plasma cell infiltration**

Infectious

Hematological : **bone marrow failure, thrombopathy**

PLASMA CELL MYELOMA
TREATMENT

INDICATION : Symptomatic plasma cell myeloma *(with CRAB type symptoms)*
Presence at diagnosis of unfavorable risk factor(s) is not by itself an indication to treatment

Bortezomib, Lenalidomide, Thalidomide, possibly in combination or with high dose Dexamethasone

Bortezomib + Cyclophosphamide + Dexamethasone *(high or reduced dosage)*

Carfilzomib (CFZ) *: 2nd generation proteasome inhibitor (in case of Bortezomib and immunomodulators failure)*

Radiotherapy *(solitary plasmocytoma)*

Supportive care *(transfusions of RBC, platelets, antibiotics, analgesics, bisphosphonates)*

Plasmapheresis *(hyperviscosity syndrome)*

Acccording to prognostic risk :

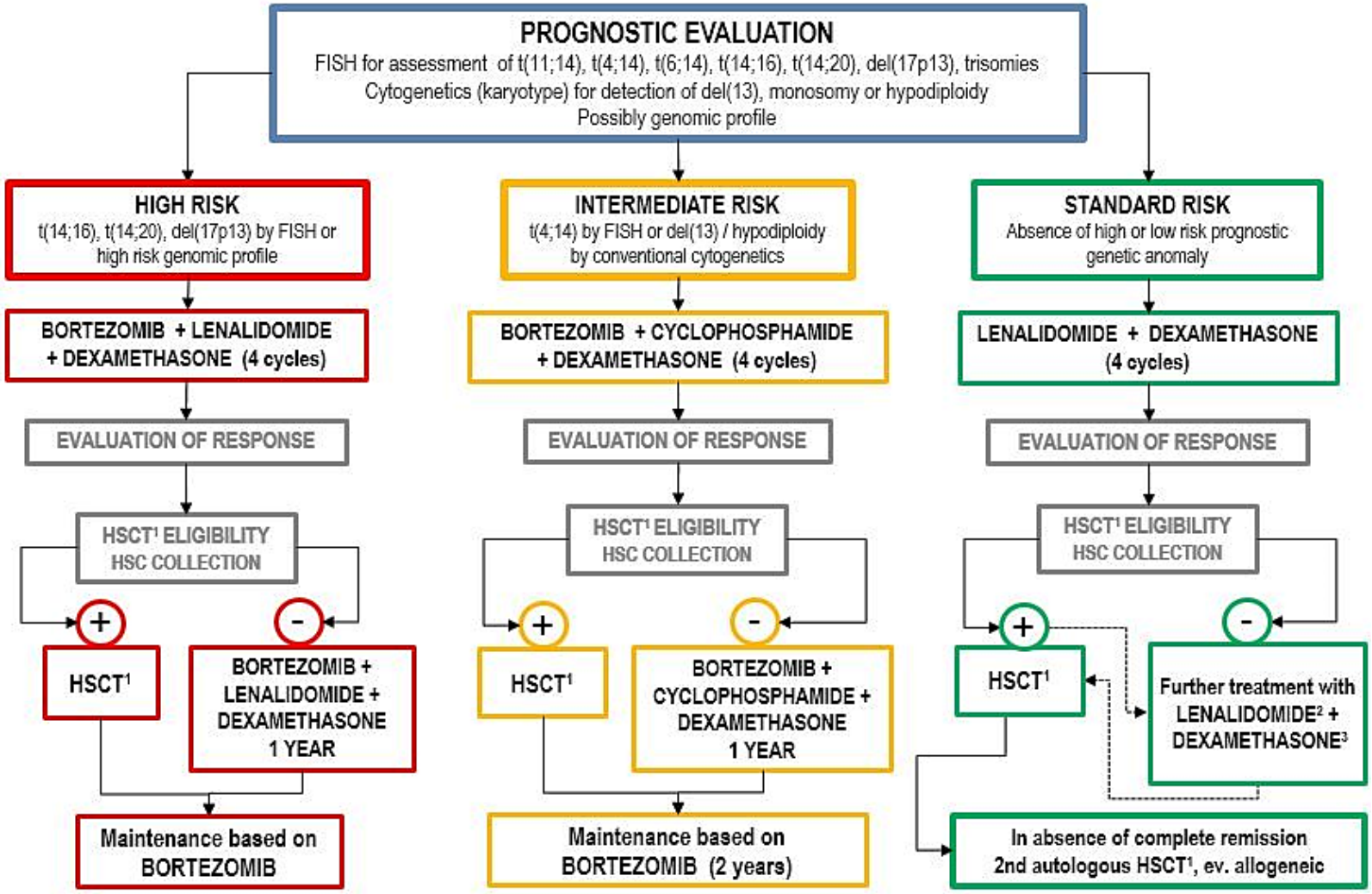
Intensification with autologous HST[1] ≤ 65-70 years[2]

Allogeneic transplant *(stem cell or bone marrow)* **≤ 55-60 years, possible cure, important treatment related mortality, GVH +++**

Allograft with reduced intensity conditioning in certain cases, but not if presence of unfavorable risk factor(s)

[1] Hematopoietic Stem cell Transplantation (peripheral blood stem cells or bone marrow)
[2] Age limit is not precisely defined. According to clinical status and performance score, the age limit may be adapted

PLASMA CELL MYELOMA
TREATMENT (2)



¹HSCT : Hematopoietic Stem Cell Transplant ²Lenalidomide until progression or intolerance ³Dexamethasone for 12 months

After Rajkumar S.V. : Selection of initial chemotherapy for symptomatic multiple myeloma; November 2014, UpToDate.

MATURE B-CELL LYMPHOID NEOPLASMS

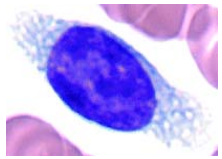
Contribution of immunological markers, cytogenetics and molecular biology

	sIg	CD19	CD5	CD23	CYTOGENETICS	OTHERS
CLL	+ / -	+	+	+	Fish : del(13q) (50%), +12 (~ 20%), del(11q), del17p, del(6q) (~10%)	CD200 +
FL	+	+	-	-	t(14;18)(q32;q21), t(3q27)	CD10 +, BCL2
SMZL	+	+	-	-		
MCL	+	+	+	-	t(11;14)(q13;q32)	Cyclin D1
HCL	+	+	-	-		TRAP +, CD11c + CD25 + , CD103 +
B-PLL	+	+	- / +	- / +	Del 17p (~ 50%) Del 13q14 (~ 25%)	

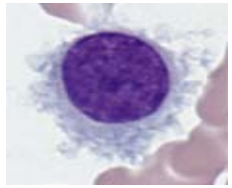
	CD123[1]	CD25	CD11c	CD103
SMZL	1 / 29 3%	18 / 28 64%	10 / 26 38%	0 / 25 0%
HCL	22 / 23 95%	24 / 25 96%	25 / 25 100%	25 / 25 100%
HCL VARIANT	1 / 11 9%	0 / 11 0%	11 / 11 100%	4 / 11 36%

CLL : Chronic lymphocytic leukemia
SMZL : Splenic B-cell marginal zone lymphoma
HCL : Hairy cell leukemia
FL : Follicular lymphoma
MCL : Mantle cell lymphoma
B-PLL : B-cell prolymphocytic leukemia
BCL2 : B-cell Leukemia / Lymphoma 2 Protooncogene, inhibitor of apoptosis or cell death

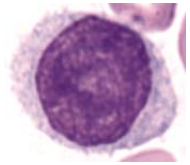
The contribution of morphology remains paramount for the differential diagnosis of splenic B-cell marginal zone lymphoma, hairy cell leukemia and its variant form as for prolymphocytic B-cell leukemia



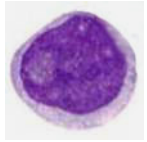
Splenic marginal zone B-cell lymphoma
(Villous lymphocytes : hairy pattern at the poles of cytoplasm)



Hairy cell leukemia
("Hairy" pattern of cytoplasm)



Hairy cell leukemia variant
("Hairy" pattern of cytoplasm + big nucleolus)

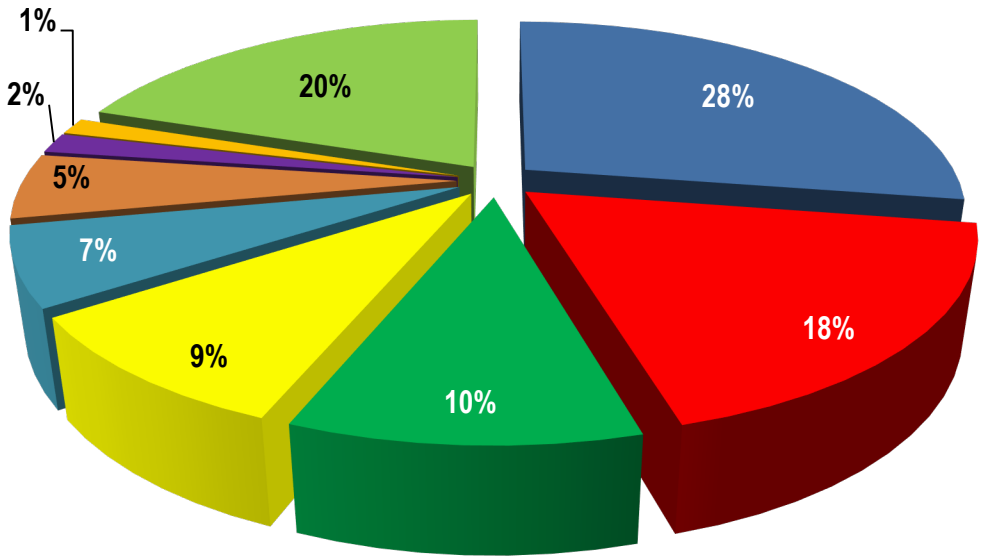


Prolymphocytic leukemia
(Cell with big nucleolus)

[1] *Del Giudice I. et coll. : The diagnostic value of CD123 in B-cell disorders with hairy or villous lymphocytes. Haematologica 2004; 89 : 303-308.*

MATURE T- AND NK-CELL LYMPHOID NEOPLASMS

RELATIVE FREQUENCY OF MATURE T / NK CELL LEUKEMIA / LYMPHOMA



- Peripheral T-cell lymphoma, NOS (PTCL)
- Angioimmunoblastic T-cell lymphoma (AILT)
- Extranodal T / NK-cell lymphoma (E-NK/T)
- Adult T-cell leukemia / lymphoma (ATLL)
- Anaplastic large cell lymphoma ALK + (ALCL, ALK+)
- Anaplastic large cell lymphoma ALK - (ALCL, ALK -)
- Primary cutaneous anaplastic large cell lymphoma (C-ALCL)
- Hepatosplenic T-cell lymphoma (HSTL)
- Other T-cell lymphomas

Represent roughly 15% of lymphoid neoplasms (B-cell lymphoid neoplasms about 85%)

PERIPHERAL T-CELL LYMPHOMA (PTCL), NOS

Isolated lymphadenopathy(-ies) : 38%

Lymphadenopathies and extranodal disease : 49%
[skin, digestive system, lungs (relatively rare), salivary glands, nervous system]

Extranodal disease only : 13%, bone marrow : 20%

Splenomegaly : 24%, hepatomegaly : 17%

B symptoms : ~ 35% of cases

⇗ LDH : 50%, hypergammaglobulinemia : 14%

Leukemic presentation rare

Aggressive disease : generally poor response to chemotherapy, frequent relapses

Prognosis : depends notably of the IPI score (age, ECOG clinical score, Ann-Arbor stage, extranodal disease, LDH level), presence or not of bone marrow infiltration

Immunophenotype :

CD3 + / -, CD2 + / -, CD5 + / -, CD7 - / +,
CD 4 > CD8, frequent losses of CD5, CD7, CD52;
CD30 - / +, CD56 - / +, CD10 -, BCL6 -, CXCL13[1] -, PD1[2] -

Cytogenetics :

Chromosomal anomalies in > 90% of cases but without specificity

Molecular biology :

Rearrangement of TCR genes

ANGIOIMMUNOBLASTIC T-CELL LYMPHOMA (AILT)

Lymphadenopathies : 76-95%

Hepatomegaly : 50-70%, splenomegaly : 70%, bone marrow : 30-60%

Skin rash : 20-60%, polyarthritis : 20%, pleural effusion, ascites : 20-35%

B symptoms : 70-85%

Symptomatic anemia : 20-50% (Coombs + ~ 30%)

⇗ LDH : 70%, ⇗ CRP : 45%

Polyclonal hypergammaglobulinemia : 30-80%

Aggressive disease : possible remission, frequent relapses

Prognosis : depends on IPI score

Immunophenotype :

CD3 +, CD2 +, CD5 +, CD4 + ou CD4 / 8 +,
CD10 + / -, BCL6 + / -, CXCL13[1] +, PD1 +[2]

Cytogenetics :

Numerous unspecific cytogenetic anomalies,
the most frequent are : +3 and / or +5 and / or + X

Molecular biology :

Rearrangement of TCR genes (75-90%),
of Ig heavy chains (25%)
(expansion of 2nd B clone), EBV, HHV-6[3] fréquent

[1] CXCL13 : C-X-C motif chemokine 13 [2] PD1 : Programmed Death 1 [3] HHV6 : Herpes virus

ADULT T-CELL LEUKEMIA / LYMPHOMA (ATLL)

Japan (1977), Caribbean, central Africa

Clinical variants: ***Acute*** *(most frequent form)*
Lymphomatous
Chronic
Indolent

Lymphadenopathies, hepatosplenomegaly

Cutaneous infiltration *(rash, papules, nodules)*

Leucocytes : 5-100 G / L *(lymphocytes with lobated nuclei)*

Association with HTLV-1 virus

Hypercalcemia

Prognostic factors : clinical variant, age, clinical stage, calcemia, LDH , molecular biology *(absence of mutation in NOTCH1 et FBXW7 genes and / or presence of N-K-Ras or PTEN alterations and / or early post-induction detection of clonal rearrangement of Ig / TCR genes over a given threshold are predicitive of relapse)*

Immunophenotype :

CD2 +, CD3 +, generally CD4 +, CD5 +, CD 7 -, CD8 -, CD25 +, CD30 - / +

Immunohistochemistry :

ALK negative

Cytogenetics :

No specific chromosomal anomaly

Molecular biology :

Rearrangement of TCR genes

ANAPLASTIC LARGE CELL LYMPHOMA (ALCL)

Lymphadenopathies and extranodal involvement :
skin, bone, soft tissues, lung, liver (less frequently nervous and digestive systems), bone marrow : 10-30%

***V*ariants :** **Classical**
Atypical : small cells
lymphohistiocytic
monomorphic

Predictive factors : **ALK status (+ ou -)**
IPI score
β_2-microglobuline

Prognosis : **more favorable with ALK expression**

Immunophenotype :

CD30 +, ALK + / -, CD25 +, CD4 + / -, CD23 - / +, CD43 +, EMA + (Epithelial Membrane Antigen)

Genetics and molecular biology :

ALK + lymphoma : several translocations implicating *ALK gene* located in 2p23 and various partners. Predominant translocation is t(2;5)(p23;q35) leading to fusion between *ALK (2p23) and NPM* (nucleophosmine) (5q35) genes : 84% of cases

Rearrangements of TCR genes in the majority of cases
Rearrangement *ALK-NPM*

T-CELL PROLYMPHOCYTIC LEUKEMIA (T-PLL)

Hepatosplenomegaly, multiple lymphadenopathies, occasionally serosal effusions (pleura)

Leukocytosis > 100 G / L (> 200 G / L in 50% of cases)

Skin infiltration (20% of cases)

Aggressive disease

Treatment : anti-CD52 (Alemtuzumab) alone
FMC *(Fludarabine, Mitoxanthrone, Cyclophosphamide)* **followed by Alemtuzumab**

Immunophenotype :

CD2 +, CD3 + (possibly weakly), CD7 +, CD52 +,CD4 + / CD8 - (60%); coexpression CD4 / CD8 (25%); CD4 - / CD8 + (15%), CD1a negative even if 25% CD4 + / CD8 +, CD52 +

Cytogenetics :

inv(14)(q11q32), t(14;14)(q11;q32), t(X;14)(q28;q11) (~90% of cases). Anomalies of chromosome 8, del(6q), del(11q), del(12p)

Molecular biology :

Rearrangement of TCR genes

T-CELL LARGE GRANULAR LYMPHOCYTIC LEUKEMIA (T-LGL)

Severe neutropenia, anemia ± *(occasionally severe with erythroblastopenia)*

Splenomegaly

Frequent presence of autoantibodies, immune complexes and hypergammaglobulinemia

Association with rheumatoid arthritis *(Felty syndrome)*

Usually indolent clinical course, rarely aggressive

Treatment : Methotrexate *(low dose)* **± steroids or Cyclophosphamide ± steroids or Cyclosporin**

Immunophenotype :

CD3 +, CD2 +, CD8 +, CD4 -/+, CD57 + et CD 16 + (> 80% of cases)

Molecular biology :

Rearrangement of TCR genes

MYCOSIS FUNGOIDES / SEZARY SYNDROME

MYCOSIS FUNGOIDES :

Cutaneous mature T-cell lymphoma : Patches, plaques, possibly erythrodermia
Possible lymphnode, blood and visceral involvement

SEZARY SYNDROME

Defined as a distinct cutaneous T-cell lymphoma with pruritic erythrodermia and leukemic involvement ***(Sézary cells : CD4 + / CD7 - and CD4 + / CD26 - by flow cytometry).*** **Clonality of blood T-lymphocytes identical to skin infiltrating lymphocytes. Possible bone marrow or splenic involvement**
(exact incidence not well known). **Associated endogenous immunodeficiency**

Treatment :
Usually combination of topical *(i.e. extracorporeal photopheresis)* **and monochemotherapy** *(i.e. Retinoids, Interferons, Methotrexate low dose)*
Many other chemotherapeutic agents have limited efficacy
Alemtuzumab (anti-CD52) and Brentuximab vedotin (anti-CD30) appear to be effective in some severe and/or refractory forms

Immunophenotype :

Inconstant phenotypic anomalies with therefore difficult characterization : CD2 +, CD3 +, CD5 +, CD4 + (generally), CD8 -, CD26 -, CD7 - (or weakly +), CD30 +, CD52 +

Molecular biology :

Rearrangement of TCR genes

After : Olsen A.E. & Rook A.H. Clinical presentation, pathologic features and diagnosis of Sézary Syndrome; May 2013, UpToDate.
Kim E.J. & Rook A.H. Treatment of Sézary Syndrome; October 2014, UpToDate.
NCCN Guidelines Version 1.2015 Mycosis fungoides / Sézary Syndrome.

OTHER MATURE T / NK-CELL LYMPHOMAS

Chronic lymphoproliferative disorder of NK-cells
Aggressive NK-cell leukemia
Systemic EBV + T-cell lymphoproliferative disorders of childhood
Extranodal NK / T-cell lymphoma, nasal type
Enteropathy-associated T-cell lymphoma
Hepatosplenic T-cell lymphoma
Subcutaneous panniculitis-like T-cell lymphoma
Primary cutaneous CD30 positive T-cell lymphoproliferative disorders
Primary cutaneous gamma-delta T-cell lymphoma

Being quite rare, these entities are not developed in this synopsis

HODGKIN LYMPHOMA

SYMPTOMS AND CLINICAL SIGNS

Lympadenopathies

Mediastinal involvement *(predominantly in nodular sclerosis variant)*

Abdominal *(and splenic)* **involvement** *(predominantly in mixed cellularity variant)*

B symptoms :

Fever of unknowed origin, persistant et recurrent, > 38°C for 1 month
Recurrent night sweats for 1 month
Unexplained loss of 10% usual body weight during the 6 months before staging

Other symptoms : **pruritus**
pains *(generally abdominal)* **after alcohol ingestion**

HISTOLOGY

Reed-Sternberg cells *(mostly of B origin)*

Histological types : **Nodular lymphocyte predominant Hodgkin lymphoma**
Classical Hodgkin lymphoma :
- **Nodular sclerosis type**
- **Lymphocyte rich type**
- **Mixed cellularity type**
- **Lymphocyte depleted type**

HODGKIN LYMPHOMA (2)

STAGING - COTSWOLDS REVISION (1989) OF THE ANN ARBOR CLASSIFICATION

STAGE	DESCRIPTION
I	**Involvement of a single lymph node region or lymphoid structure** *(e.g. spleen, thymus, Waldeyer ring)*
II	**Involvement of two or more lymph node regions on the same side of the diaphragm** *(the mediastinum is a single site; hilar lymph nodes are lateralized)***. The number of anatomic sites involved should be indicated by suffix (e.g. II_3)**
III	**Involvement of lymph nodes regions or structures on both sides of the diaphragm**
III_1	**With or without spleen involvement (III_s) and with hilar splenic, coeliac or portal nodes involvement**
III_2	**With paraaortic, iliac or mesenteric nodes involvement**
IV	**Diffuse or disseminated involvement of one or more extranodal organs or tissues, with or without associated lymph node involvement**

At any disease stage :	**A**	**No symptoms**
	B	**Fever, sweats, loss of weight**
	X	**Bulky disease** *(widening of the mediastinum ≥ 1/3 of the internal transverse diameter of the thorax at the level of T 5/6 interspace or >10 cm maximum dimension of a nodal mass)*
	E	**Involvement of a single extranodal site, contiguous or proximal to a known nodal site**

Modified from : Lister T.A. et al. : Report of a committee convened to discuss the evaluation and staging of patients with Hodgkin's Disease : Cotswolds meeting. J Clin Oncol 1989; 7 : 1630-1636.

HODGKIN LYMPHOMA (3)
DIAGNOSIS AND PROGNOSTIC STAGING

HODGKIN HISTOLOGY ← **Lymph node excision, if necessary biopsy of other lesion(s)**

STAGING

Clinic : Status / search for B symptoms *(fever, night sweats, pruritus, weight loss)*

Laboratory : CBC, ESR, liver function tests, renal function, LDH, calcemia, albumine
Pregnancy test (♀ in childbearing age)

Imaging : If possible PET-CT, if not thoraco-abdominal CT-scan
If planned prescription of anthracycline, baseline cardiac function (EF)
If planned prescription of Bleomycin, pulmonary fonction
Bone marrow examination only if anemia, B symptoms or extended involvement

Ann Arbor / Cotswolds classification *(cf. previous page)*

STAGES I and II LOCALIZED

EORTC RISK FACTORS[2] :
- Mediastinal involvement > 1/3 of thoracal diameter
- Lymphnodes ≥ 4
- Age ≥ 50 ans
- B symptoms + ESR > 30 mm/h or ESR only > 50 mm/h

∅ → **FAVORABLE**

\+ → **LESS FAVORABLE**

STAGES III and IV ADVANCED

International prognostic score (IPS) for Hodgkin lymphoma[1]

ADAPTED TREATMENT OPTIONS

[1] Proportionnal to number of risk factors present : 1. Serum albumin < 40 g / L; 2. Hemoglobin < 105 g / L; 3. Sex ♂; 4. Age > 45 years; 5. Stage IV; 6. Leukocytes ≥ 15 G / L; 7. Lymphocytes < 0.6 G / L

[2] EORTC : European Organization for Research and Treatment of Cancer

HODGKIN LYMPHOMA (4)
TREATMENT

TREATMENT

Chemotherapy : ABVD, BEACOPP
Radiotherapy

Localized disease (Stage I or II) : Chemotherapy followed by radiotherapy

Favorable risk factors : **2 - 4 cycles of chemotherapy (ABVD) + involved fields radiotherapy**
Overall long term survival : ± 94 %

Less favorable risk factors: **4 (- 6) cycles of chemotherapy (ABVD) + involved fields radiotherapy**
Overall long term survival : ± 86 %

Advanced disease (Stage III ou IV) : **Chemotherapy (ABVD, possibly BEACOPP) 6 - 8 cycles**
(i.e. 2 more cycles after maximal response)
± Radiotherapy *(consolidation on disease bulks)*
± Autologous stem cell transplant *(advanced and / or refractory forms)*

PROGNOSTIC CRITERIA (IPS)	Number of present criteria	Global 5 years *survival* (%)
1. Serum albumin < 40 g / L 2. Hemoglobin < 105 g / L 3. Male sex 4. Age > 45 years 5. Stage IV 6. Leukocytes ≥ 15 G / L 7. Lymphocytes < 0.6 G / L	0	98
	1	97
	2	91
	3	88
	4	85
	≥ 5	67

IPS related global survival (5 years)
after chemotherapy with ABVD[1] in advanced stages

ABVD : **Adriamycine + Bleomycin + Vinblastine + Dacarbazine (DTIC)**

BEACOPP : **Bleomycin + Etoposide + Doxorubicine + Cyclophosphamide + Vincristine + Procarbazine + Prednisone** *(higher toxicity)*

Brentuximab vedotin (anti-CD30) : *after failure of chemo and autologous stem cell transplant in advanced and / or refractory disease*

[1] *Moccia A.A. et al. : International Prognostic score in Advanced-Stage Hodgkin's lymphoma : Altered Utility in the Modern Era. J Clin Oncol 2012; 30 : 3383-3388.*

Part 3

HEMOSTASIS

HEMOSTASIS
EXPLORATION METHODS

PRIMARY HEMOSTASIS

Capillary resistance
Platelet count (RI : 150 – 350 G / L)
PFA-100™ [1] (or PFA-200™)
Measure of platelet aggregation *(ADP, arachidonic acid, adrenalin-heparin, collagen, TRAP-6, U46619, ristocetin)*
Measure of platelet secretion
Quantification of platelet receptors by flow cytometry
Examination of platelet morphology by electronic microscopy

SECONDARY HEMOSTASIS ***(Coagulation)***

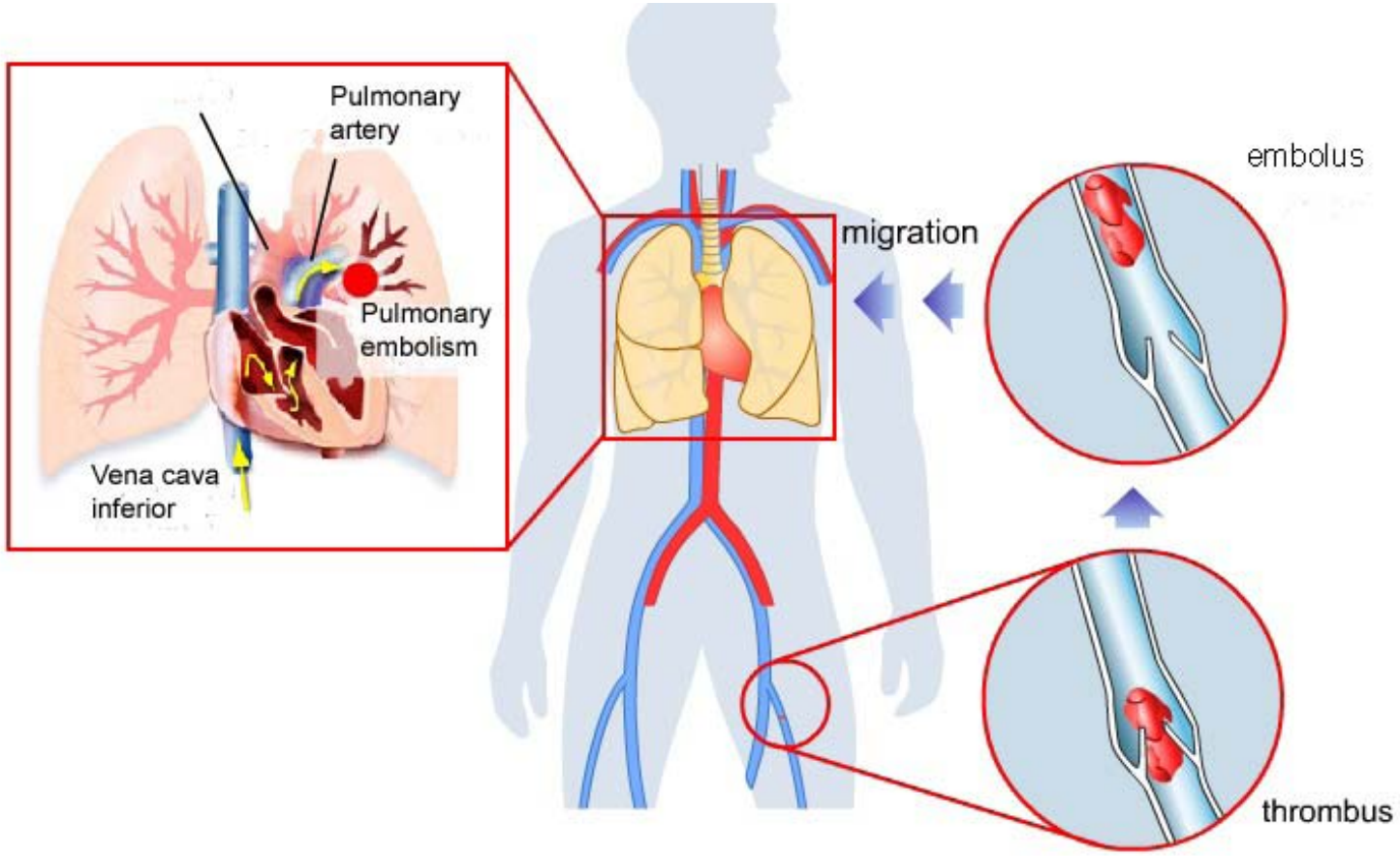
Prothrombin time (PT, Quick) *(Exploration of extrinsic pathway)*
Activated partial thromboplastin time (aPTT) *(Exploration of intrinsic pathway)*
Thrombin time (TT) *(Exploration of fibrin formation)*
Fibrinogen and factors II, V, VII, VIII, IX, X, XI, XII level
Investigation of factor XIII deficiency *(Fibrin stabilizing factor)*
Investigation of activation *(Fibrin monomers and D-dimers)*

TERTIARY HEMOSTASIS

Euglobulins lysis time
Fibrinogen level
D-Dimers level
Plasminogen level
α2-antiplasmin level
Plasminogen level
PAI-1 level *(Plasminogen Activator Inhibitor-1)*

[1] **PFA-100™ / PFA-200™** *(Platelet Function Analyzer)* **: *in vitro* measure of the time to occlusion of a membrane** *(measure of platelet adhesion and aggregation process)*. **Replaces, if device available, the classical bleeding time**

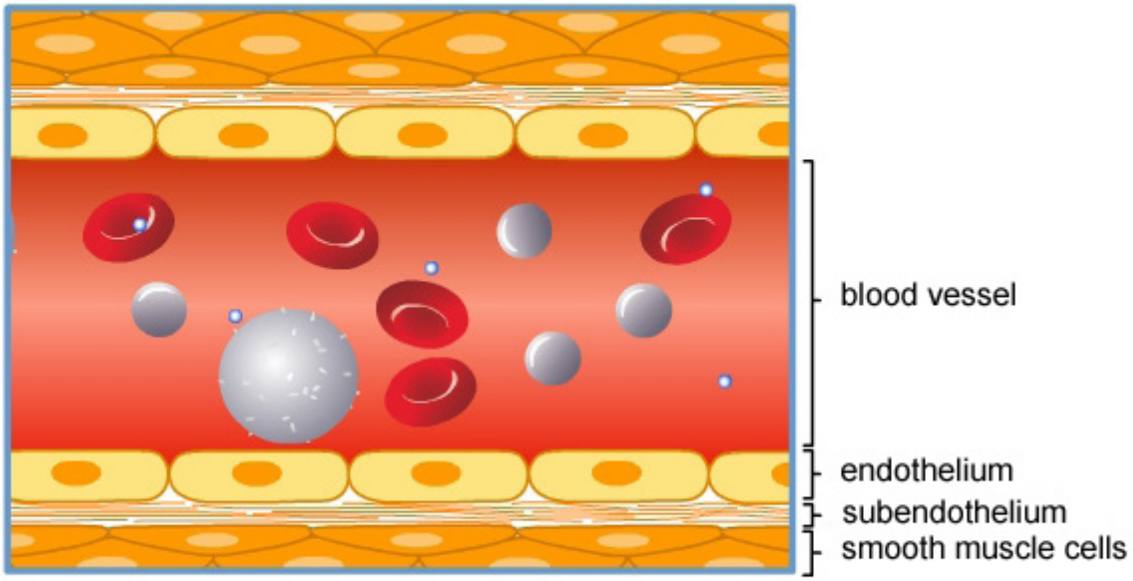
THROMBUS AND EMBOLUS

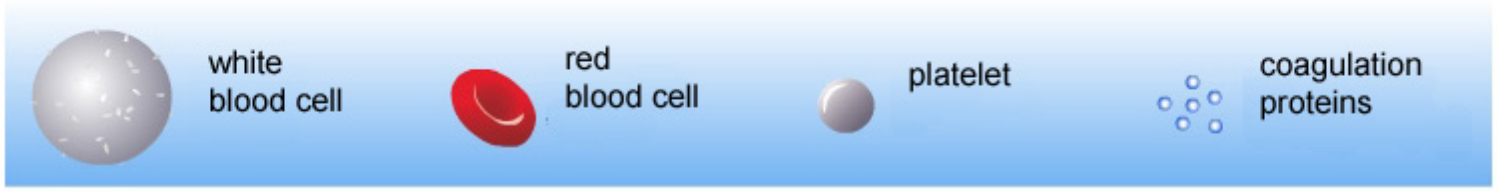


Thrombus : **inappropriate clot formation in a blood vessel** *(artery or vein)*
Embolus : **migrating thrombus**

MAIN ACTORS OF HEMOSTASIS

Blood vessels
Platelets
Coagulation proteins

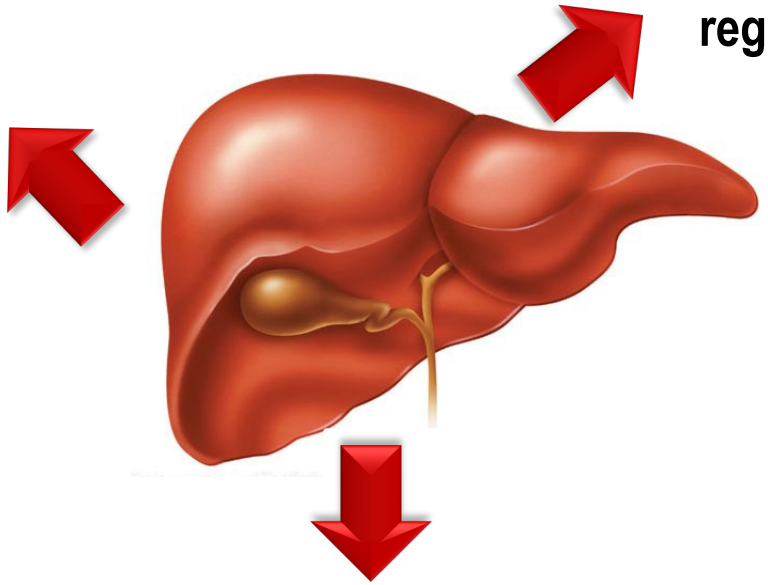




ROLE OF THE LIVER IN HEMOSTASIS

Synthetizes most of the proteins involved in **coagulation and its regulation**

Synthetizes most of the proteins involved in **fibrinolysis and its regulation**



Synthetizes **thrombopoietin** responsible for **platelet production** from the megakaryocytes

STEPS OF HEMOSTASIS

PRIMARY HEMOSTASIS

Vascular time

Vasoconstriction *(vascular spasm)*

Platelet time

Platelet adhesion to the vessel lesion
Platelet plug formation and stabilization

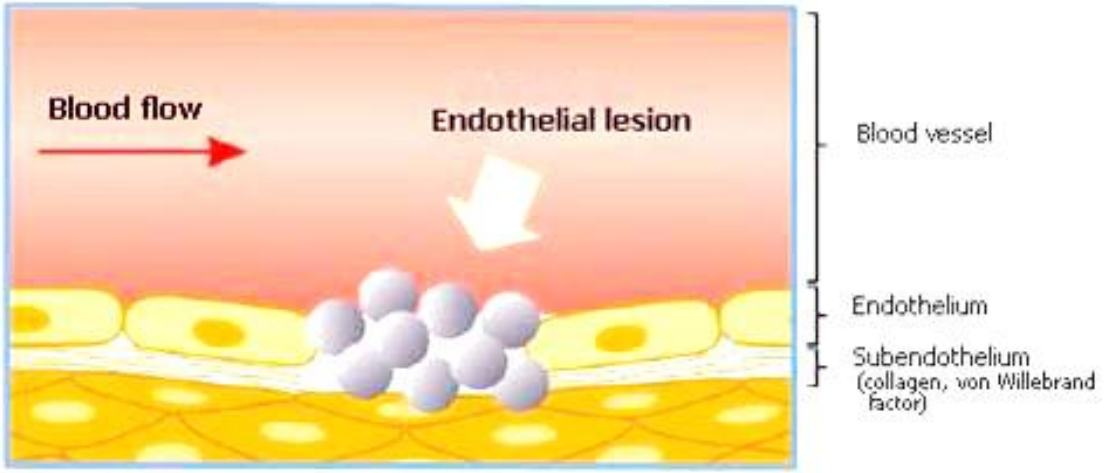
SECONDARY HEMOSTASIS *(coagulation)*

Coagulation cascade
Clot formation

TERTIARY HEMOSTASIS *(fibrinolysis)*

Clot lysis

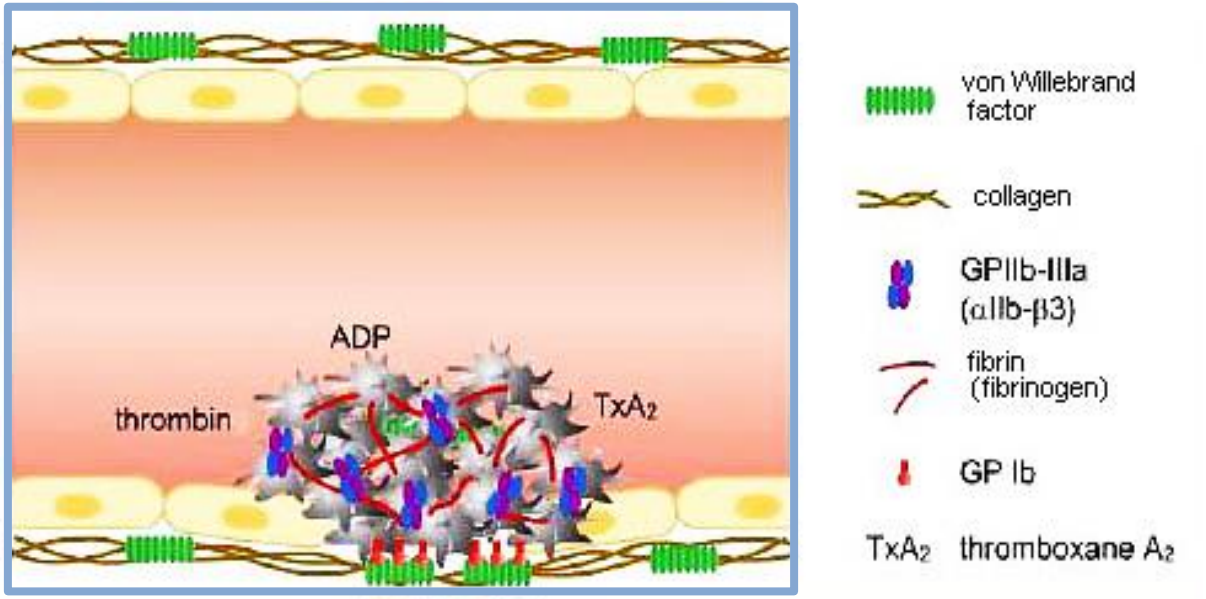
STEPS OF PRIMARY HEMOSTASIS



Platelet adhesion

Platelet activation

Platelet aggregation



Formation of platelet plug

VON WILLEBRAND FACTOR

Synthetized by endothelial cells and megakaryocytes

Composed of a series of multimers : the very high molecular weight multimers are physiologically degraded by a specific protease (ADAMTS 13), leading to prevention of spontaneous platelet aggregates formation (TTP) *(cf. p. 87-88)*

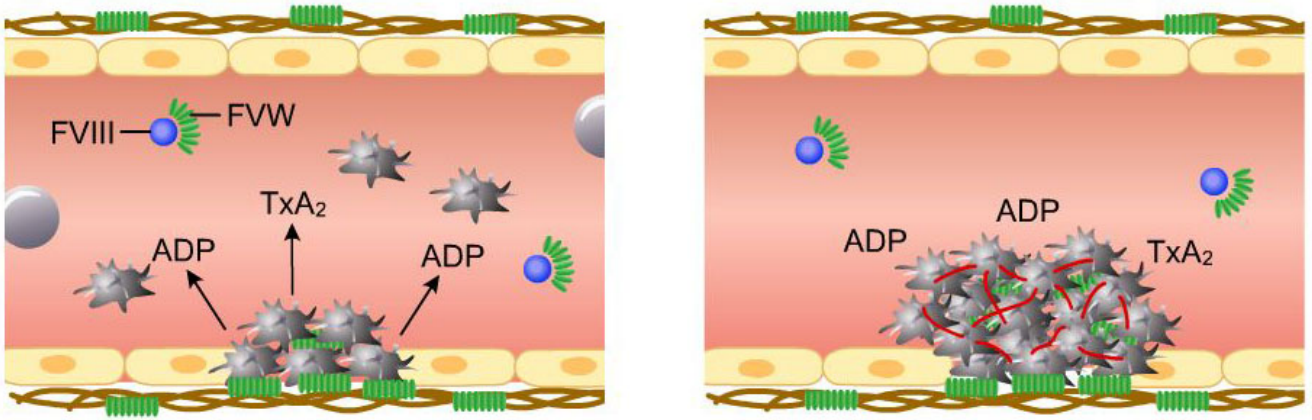
Involved, *in vitro,* in the process of platelet adhesion to subendothelial fibers

Mandatory for *in vitro* ristocetin induced platelet aggregation

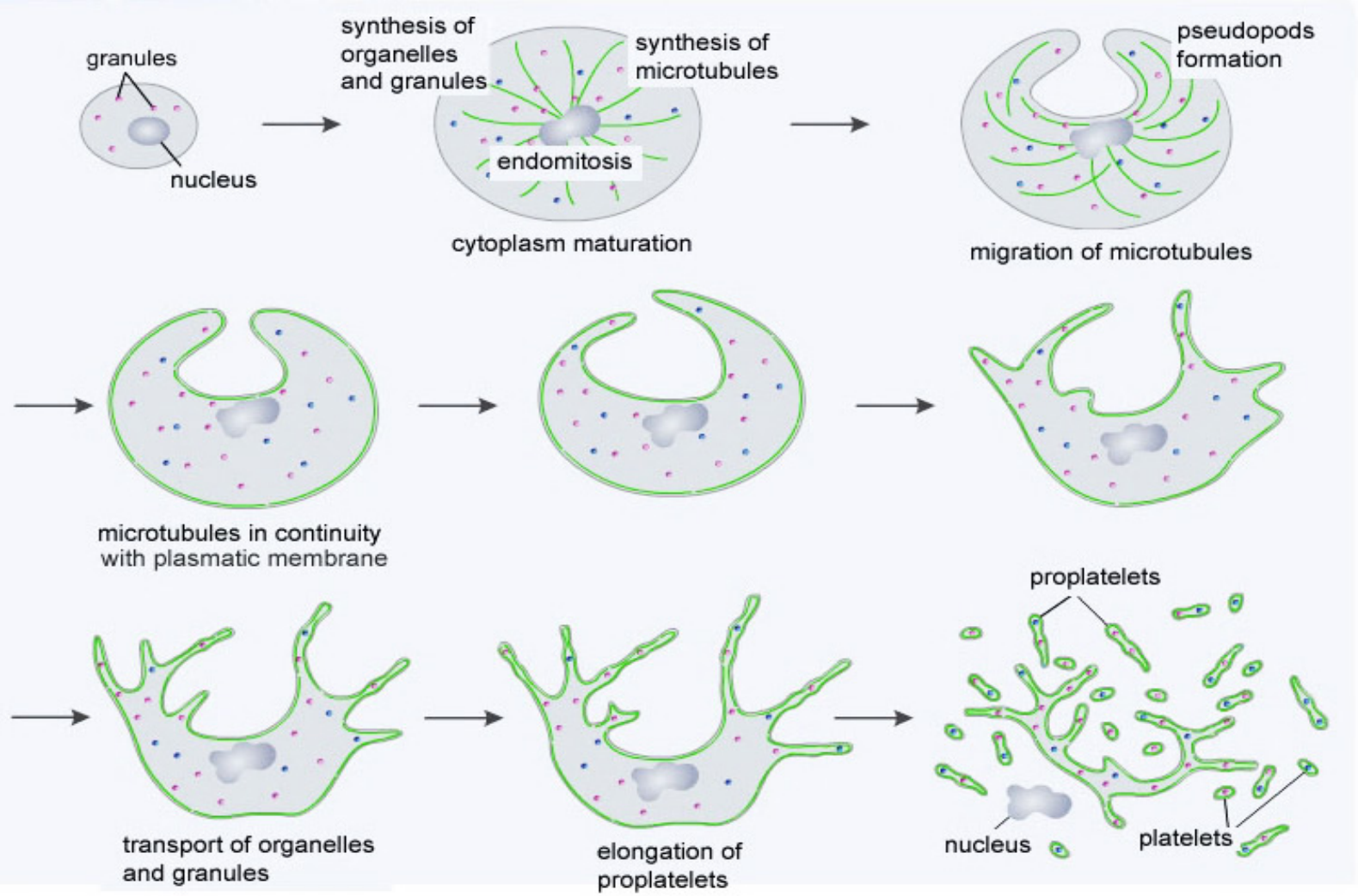
Transport of factor VIII to vascular lesion

Bound to factor VIII, it prolongs its life span

TxA_2 : Thromboxane A_2
FVW : von Willebrand factor
ADP : Adenosin Diphosphate
FVIII : Factor VIII



PLATELET PRODUCTION FROM THE MEGAKARYOCYTE



1 mature megakaryocyte produces 2'000-3'000 platelets

SECONDARY HEMOSTASIS
COAGULATION

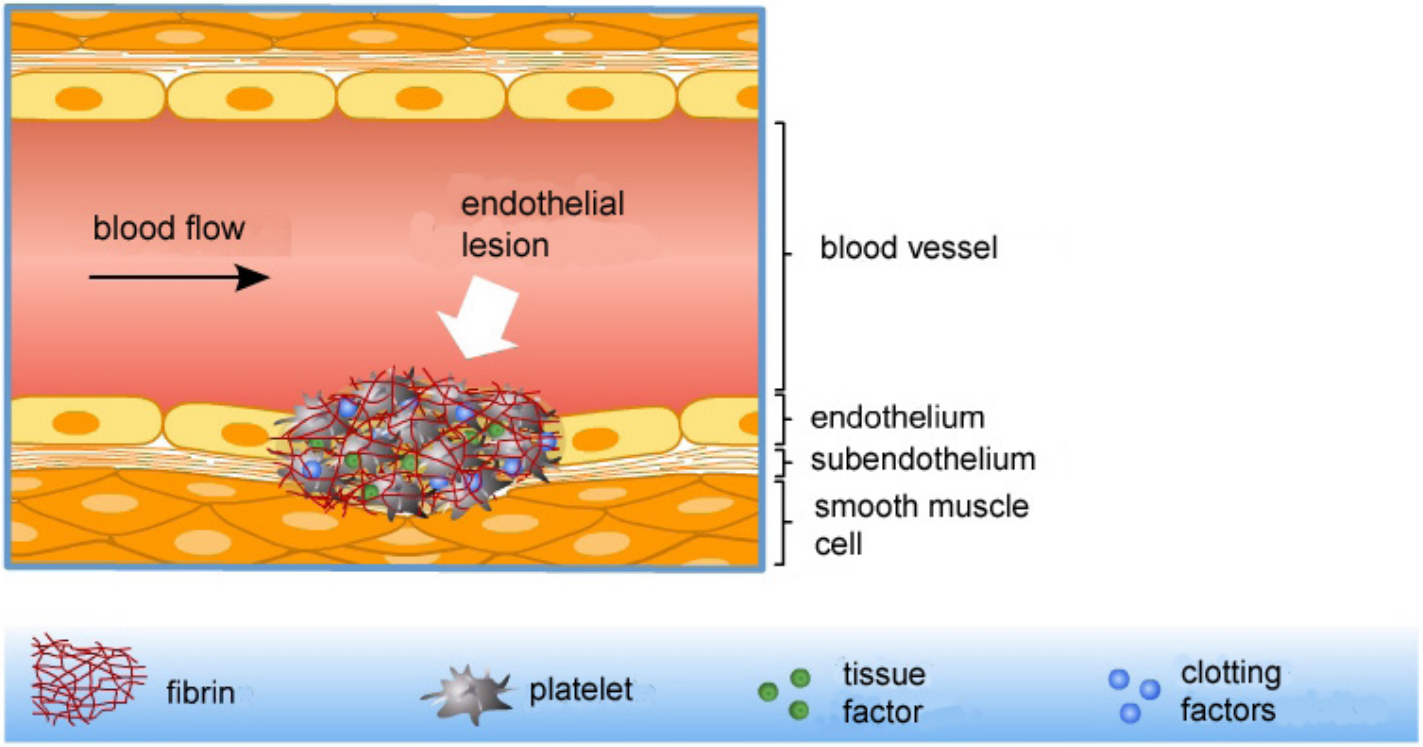
Coagulation (blood clotting) needs interaction of :

Plasmatic proteins *(coagulation factors and inhibitors)*

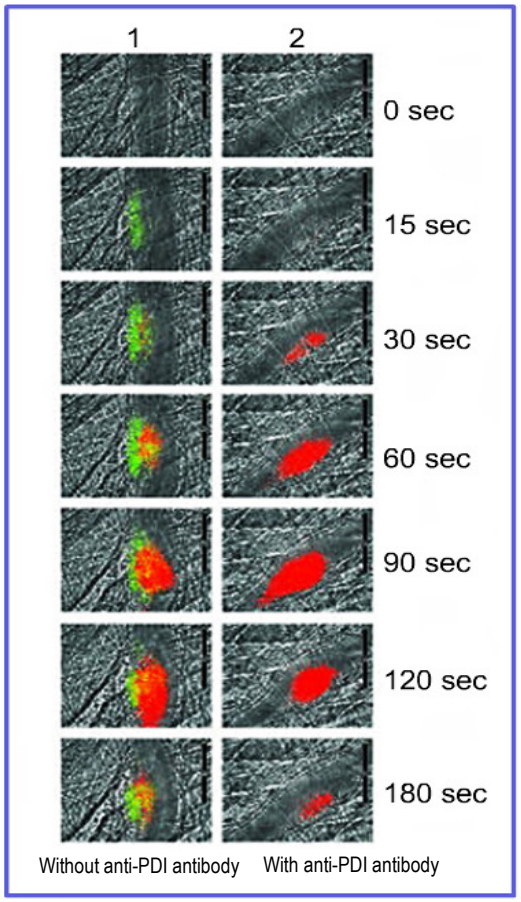
A tissular protein *(tissue factor)*

Platelets

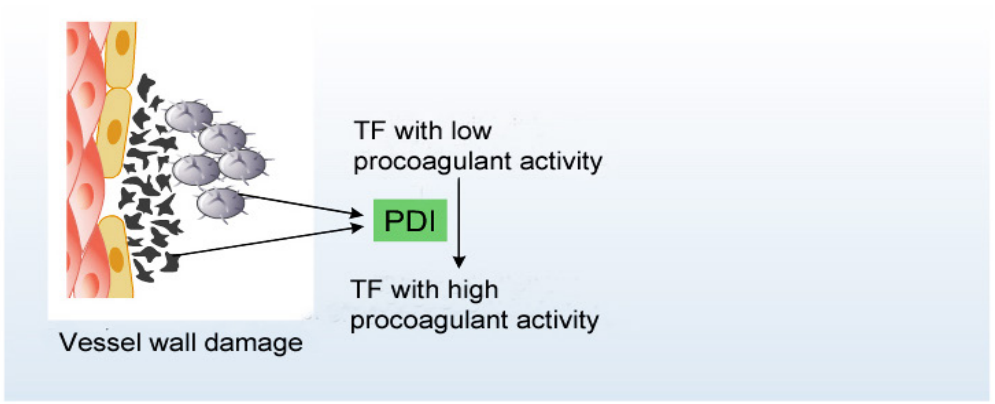
Calcium

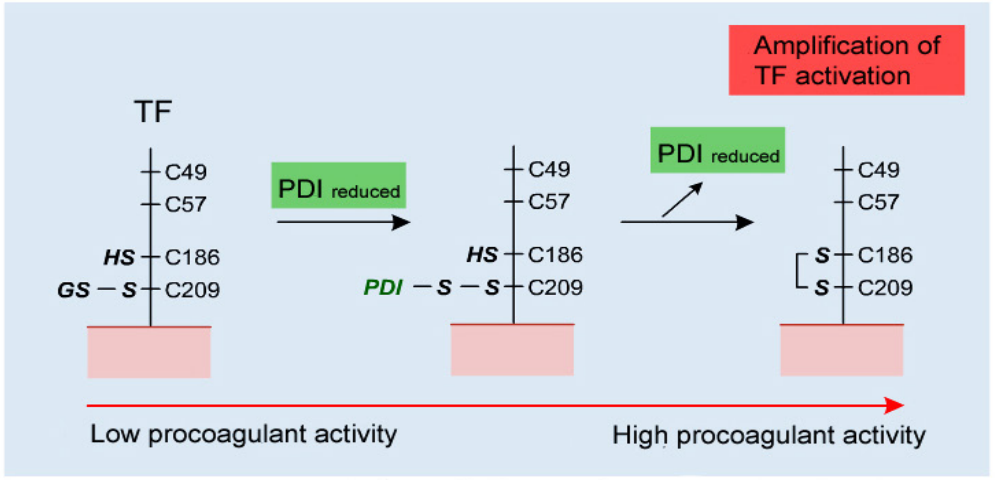


TISSUE FACTOR : MAJOR TRIGGER OF COAGULATION



In red : Platelets
In green : PDI (protein disulfide isomerase)





TF : Tissue Factor

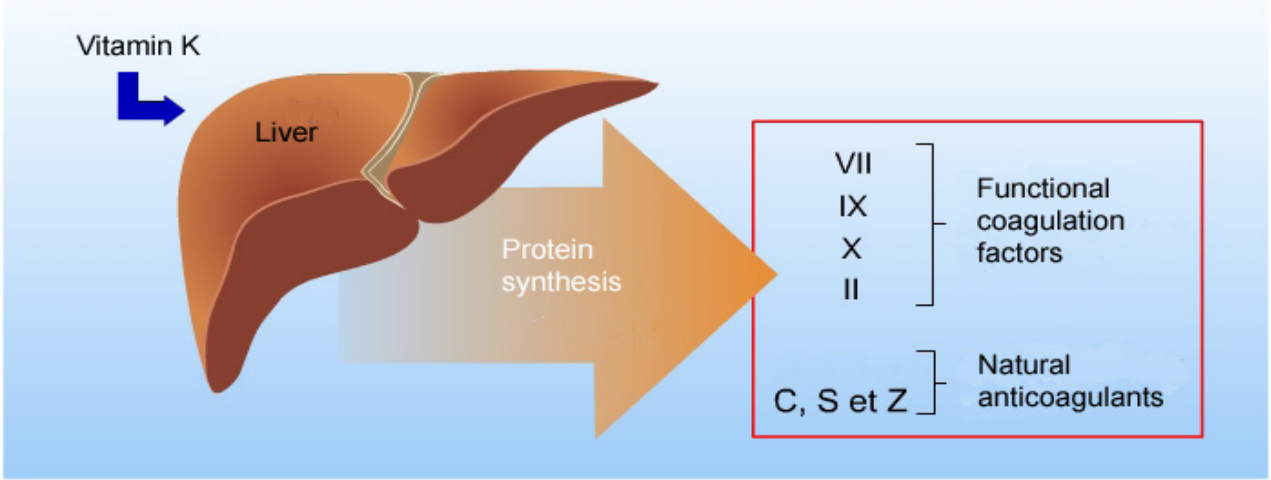
Cho J. & coll. : A critical role for extracellular protein disulfide isomerase during thrombus formation in mice. J Clin Invest. 2008; 118 : 1123-1131.

Adapted from : Reinhardt C. & coll. : Protein disulfide isomerase acts as an injury response signal that inhances fibrin generation via tissue factor activation. J Clin Invest. 2008; 118 : 1110-1122.

COAGULATION FACTORS

FACTOR	NAME	HALF-LIFE (hours)	PRODUCTION	VITAMINE K DEPENDENCE
High molecular weight kininogen	Fitzgerald factor	150	Liver	–
Prekallikrein	Fletcher factor	35	Liver	–
Factor I	Fibrinogen	90	Liver	–
Factor II	Prothrombin	65	Liver	+
Factor V	Proaccelerin	15	Liver	–
Factor VII	Proconvertin	5	Liver	+
Factor VIII	Antihemophilic factor A	12	Liver *(sinusoidal cells)*	–
Factor IX	Christmas factor or antihemophilic factor B	24	Liver	+
Factor X	Stuart-Prower factor	40	Liver	+
Factor XI	Antihemophilic factor C	45	Liver	–
Factor XII	Hageman factor	50	Liver	–
Factor XIII	Fibrin stabilizing factor	200	**α subunit :** *monocytes, megakaryocytes, platelets* **β subunit** : *liver*	–
Factor vW	von Willebrand factor	15	Endothelium Megakaryocytes	–

VITAMIN K DEPENDENT FACTORS



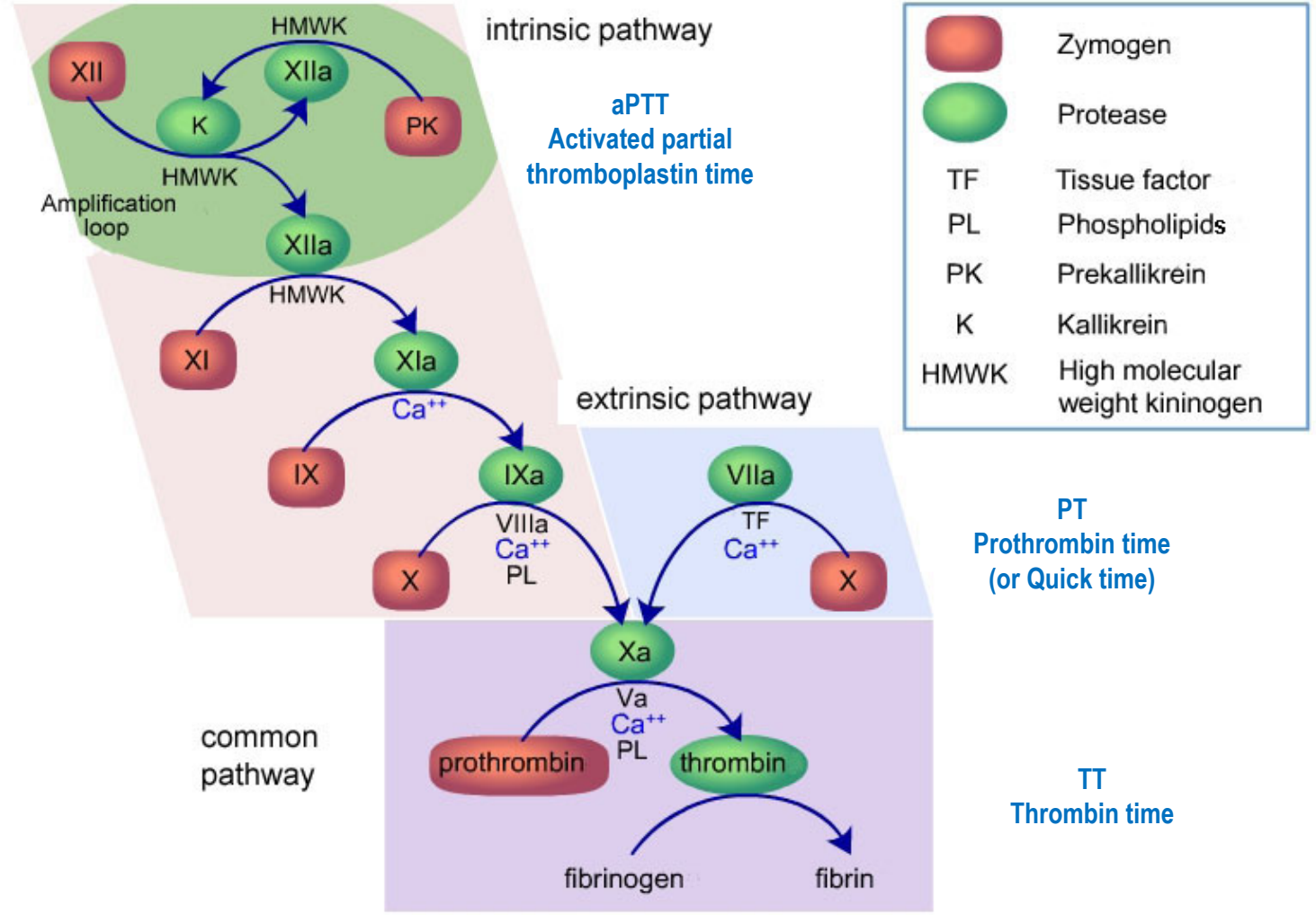
These coagulation factors are synthetized by hepatocytes

Vitamin K is necessary for complete functional synthesis

Vitamin K (liposoluble), in reduced state, works as a cofactor to a carboxylase which transforms 10-12 glutamic acid (Glu) residues in γ-carboxyglutamic acid (Gla)

Vitamin K dependent factors bind to the cell membranes through this Gla domain, in presence of Ca^{++}

COAGULATION CASCADE
CLASSICAL SCHEME



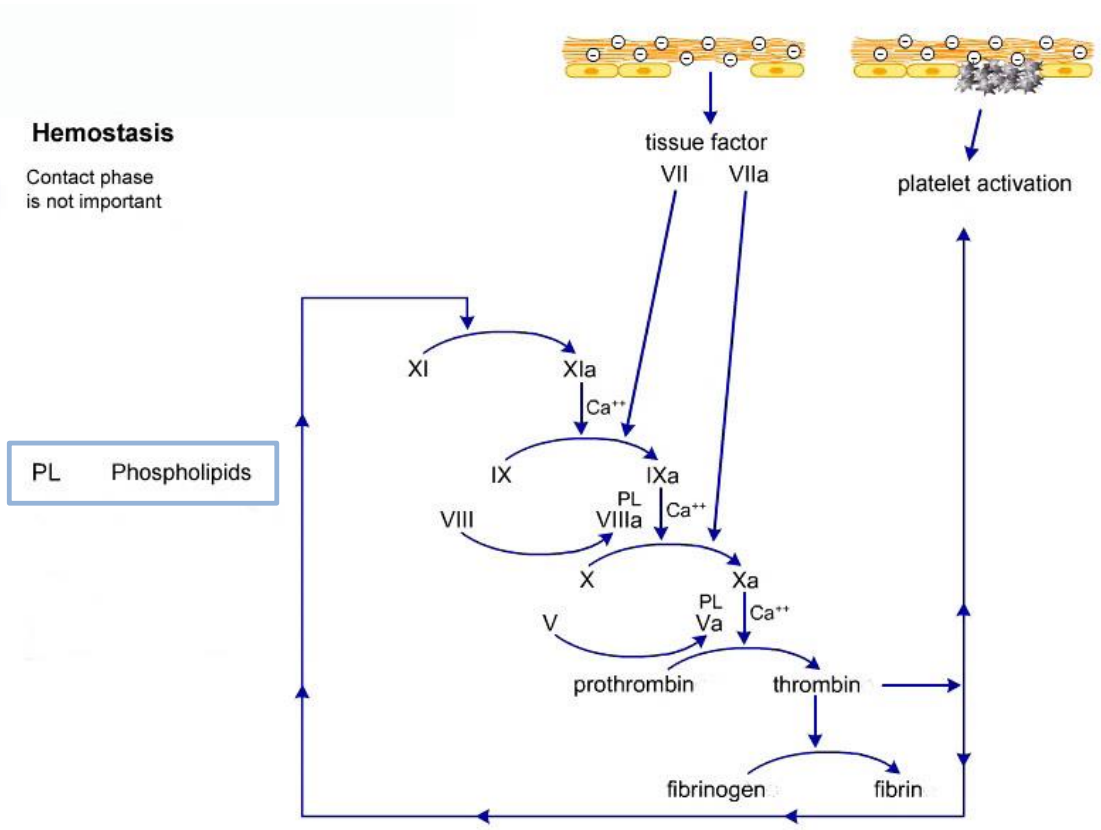
aPTT
Activated partial thromboplastin time

PT
Prothrombin time
(or Quick time)

TT
Thrombin time

Fibrinogen
Functional or quantitative dosage

COAGULATION CASCADE (2)
CONCEPTUAL CHANGES



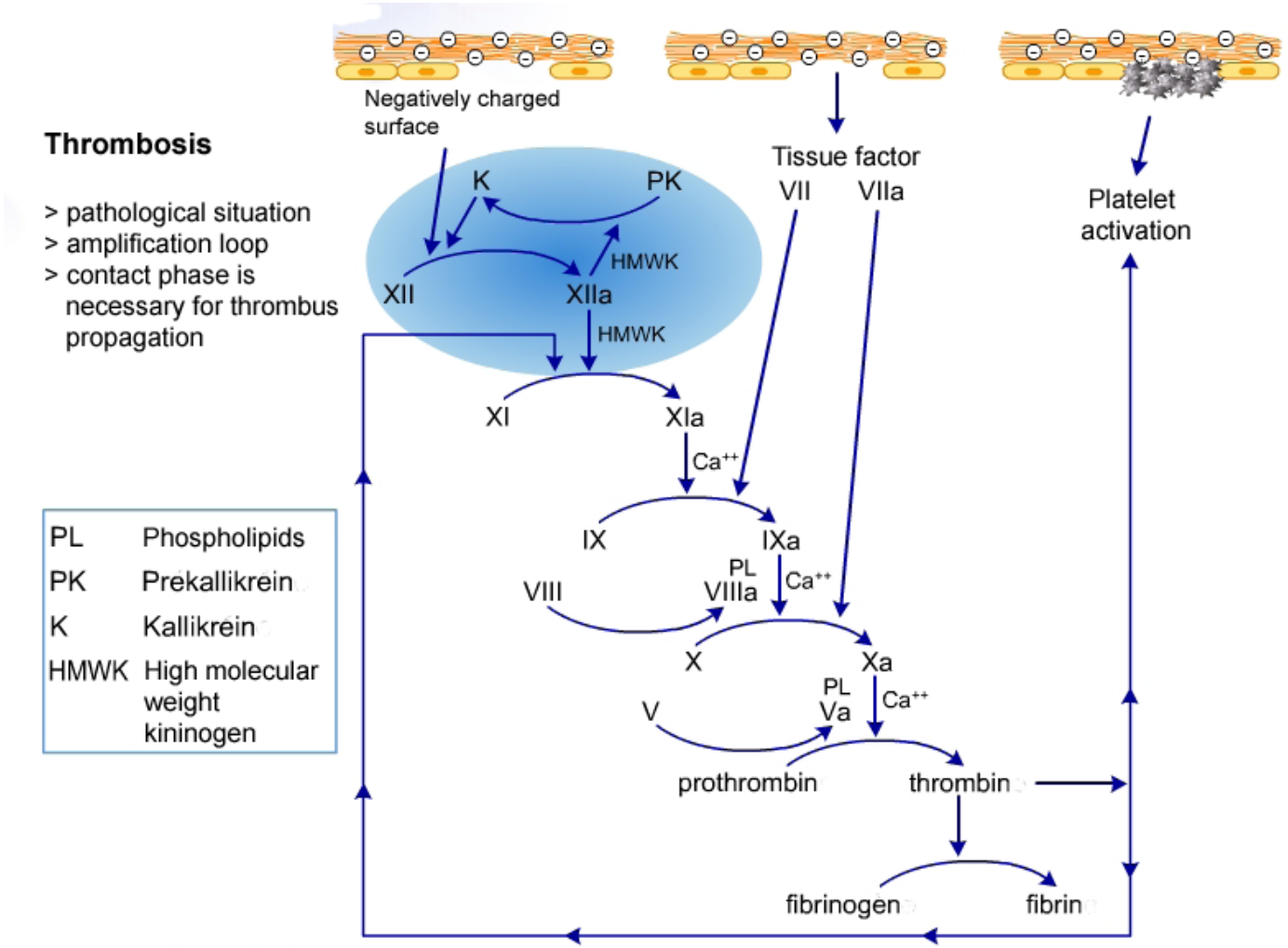
Factor XI may be activated by thrombin as well as by factor XIIa

Factor XI deficiency is responsible for bleeding whereas deficiencies in factor XII, prekallikrein or high molecular weight kininogen do not cause bleeding

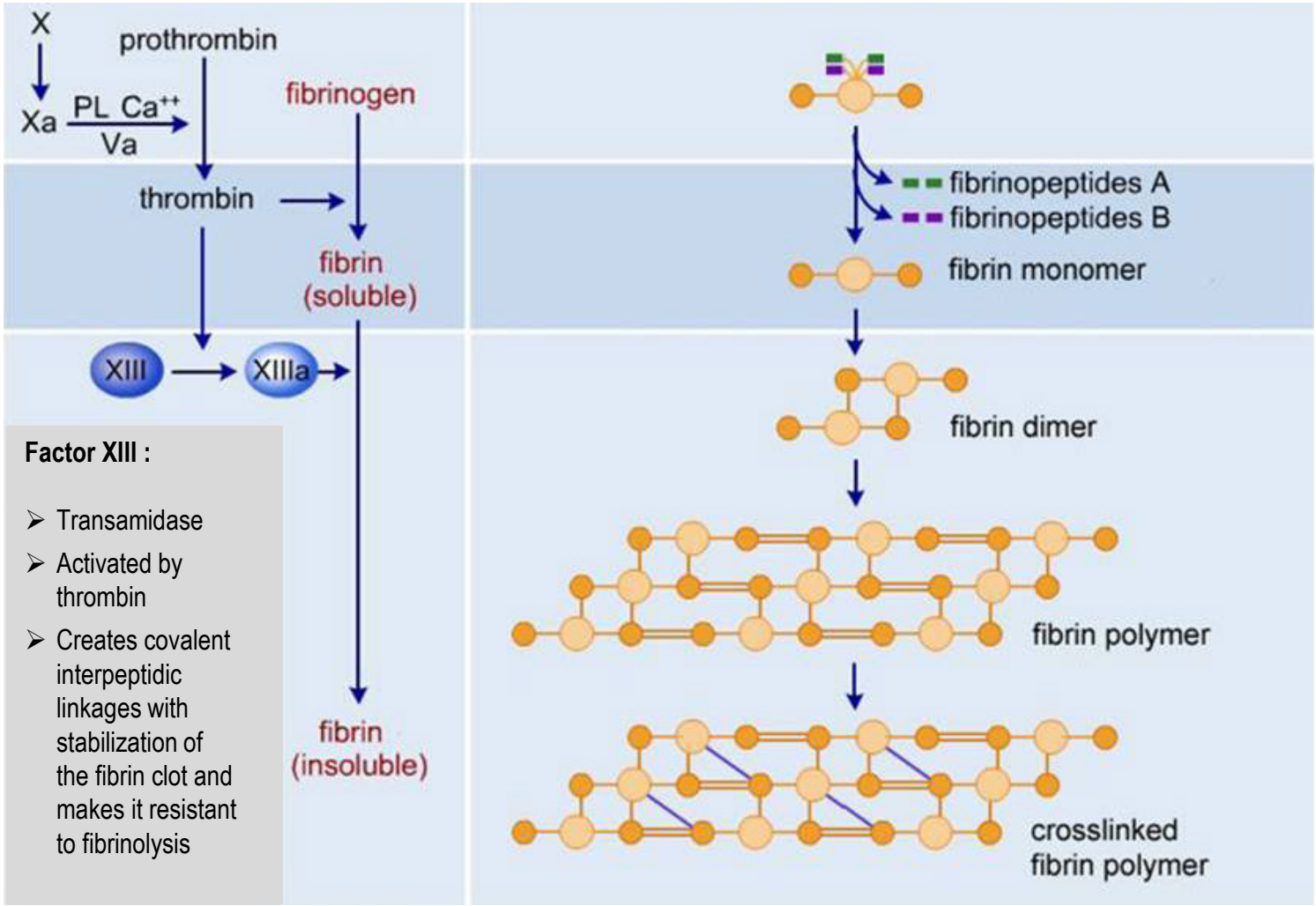
In experimental models factor XI and factor XII deficiencies have antithrombotic effect

Factor XII is activated by negatively charged surfaces, activated platelets and clot surface

COAGULATION CASCADE (3)
CONCEPTUAL CHANGES (2)



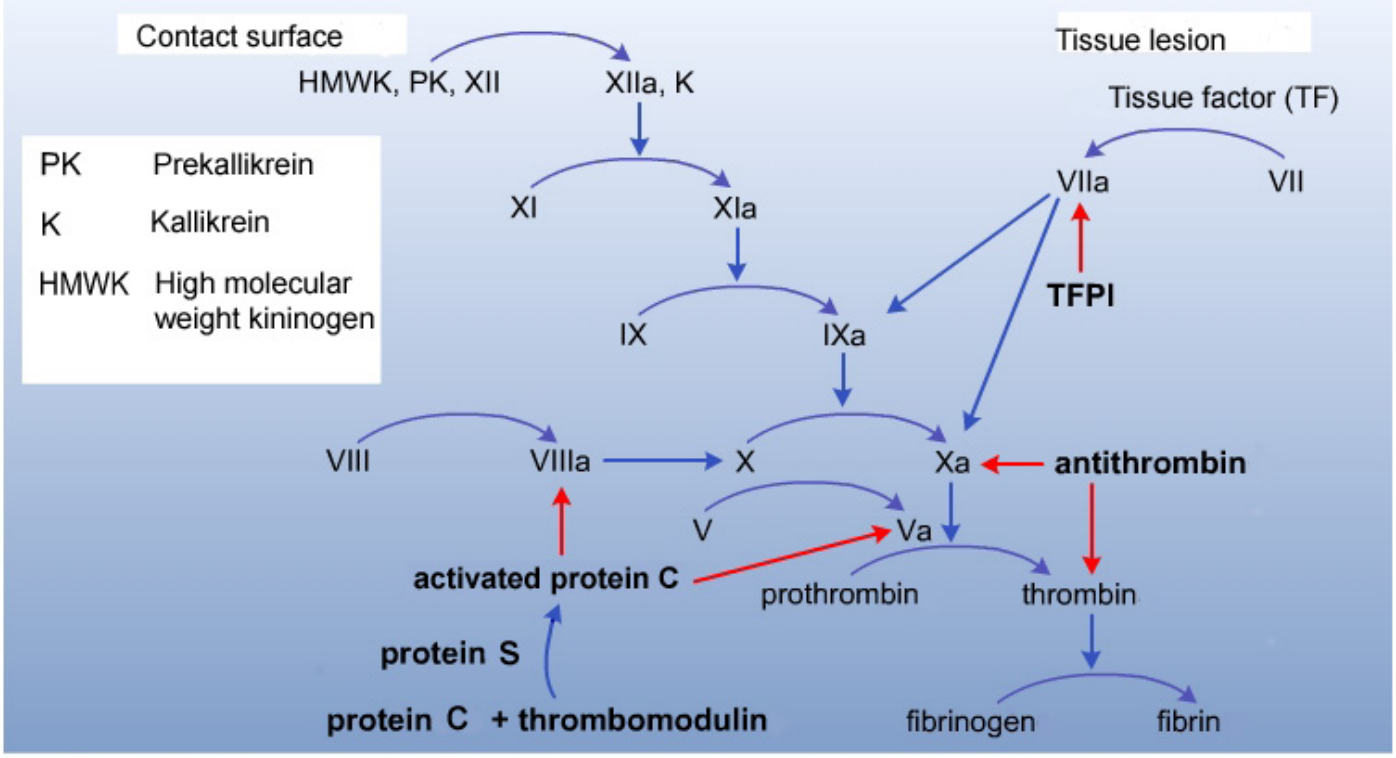
FACTOR XIII AND FIBRIN STABILIZATION



Factor XIII :

- Transamidase
- Activated by thrombin
- Creates covalent interpeptidic linkages with stabilization of the fibrin clot and makes it resistant to fibrinolysis

NATURAL ANTICOAGULANTS



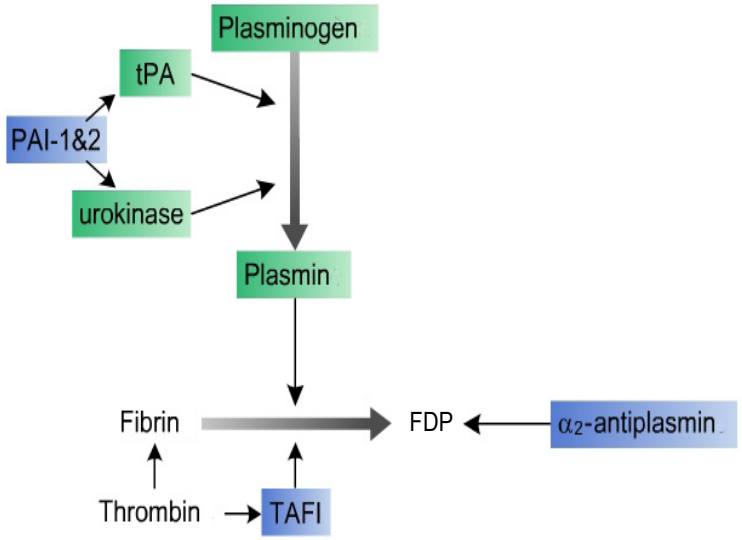
TFPI *(Tissue Factor Pathway Inhibitor)* **is an effective inhibitor of factor VII - Tissue factor complex**

Antithrombin neutralizes all procoagulant serine proteases *(thrombin, factors IXa, Xa and XIa)*

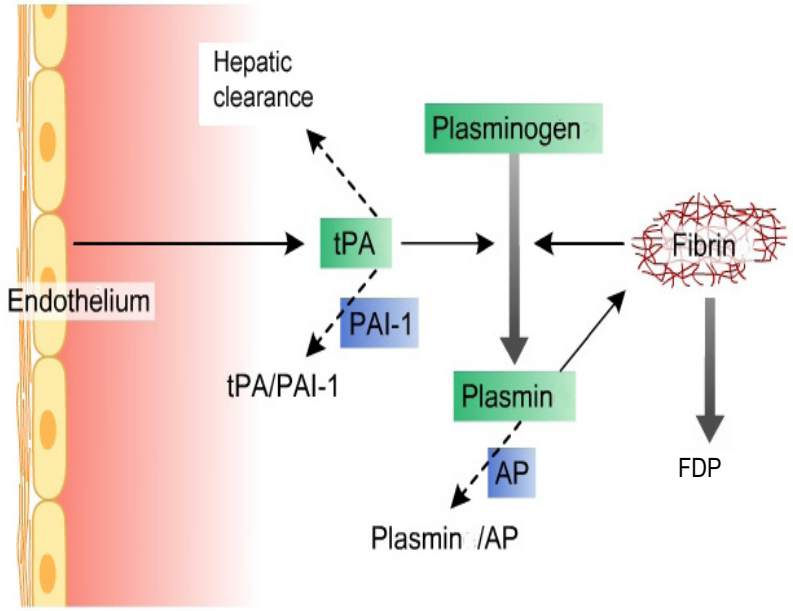
The protein C - protein S system inhibits factors Va and VIIIa

Protein S acts also as TFPI cofactor

TERTIARY HEMOSTASIS
FIBRINOLYSIS



Intravascular fibrinolysis



tPA :	Tissular Plasminogen Activator
PAI :	Plasminogen Activators Inhibitors 1 and 2
FDP :	Fibrin Degradation Products
TAFI	Thrombin Activatable Fibrinolysis Inhibitor
AP :	α_2-antiplasmin

Profibrinolytic proteins

Antifibrinolytic proteins

HEMORRHAGIC SYNDROME
PRIMARY HEMOSTASIS

Reduced capillary resistance with platelet count[1], PFA-100™[2] (or PFA-200™) tests of platelet function, coagulation, and fibrinolysis in normal range

VASCULAR PURPURA

NON INFLAMMATORY

Senile purpura
Ehlers-Danlos syndrome *(collagen abnormality)*
Vitamin A deficiency
Treatment with steroids, Cushing disease
Chronic and pigmented dermatitis
Osler disease *(Hereditary hemorrhagic telangiectasia)*

INFLAMMATORY (VASCULITIS)

Drug induced *(Penicillin, non steroidal antiinflammatory drugs)*
Autoimmune disease *(SLE, RA, PAN, Crohn's disease)*
Bacterial infection
Viral infection *(hepatitis B, CMV, EBV, parvovirus)*
Lymphoid neoplasm
Cancer
Rheumatoid purpura *(Henoch-Schönlein)*
Cryoglobulinemia
Hypergammaglobulinemia
Idiopathic

SLE : Systemic Lupus Erythematosus
RA : Rheumatoid arthritis
PAN : Panarteritis nodosa
EBV : Epstein-Barr Virus
CMV : Cytomegalovirus

[1] In case of vasculitis, immune thrombocytopenia may be found
[2] Replaces bleeding time

HEMORRHAGIC SYNDROME
PRIMARY HEMOSTASIS (2)

Prolonged occlusion time[1] (PFA-100™ or PFA-200™)

With normal platelet function tests

Thrombocytopenia
Secondary thrombocytosis

With platelet function anomaly and aPTT within normal range

Thrombopathy : acquired
hereditary
Thrombocytosis of myeloproliferative neoplasms *(cf. p.119-135)*

With platelet function anomaly and prolonged aPTT

Von Willebrand disease *(cf. p. 236-237)*

[1]Occlusion time (PFA-100™ ou PFA-200™)

	Normal *(seconds)*[1]	Aspirin	von Willebrand	Glanzmann[2]	Bernard-Soulier[2]
Col / EPI[3]	84 – 160	⇗	⇗	⇗	⇗
Col / ADP[4]	68 – 121	normal	⇗	⇗	⇗

[1] LCH-CHUV, 2015
[2] *(cf. p. 226)*
[3] Col / EPI : Collagen / Epinephrin
[4] Col / ADP : Collagen / Adenosin-5'-diphosphate

ACQUIRED THROMBOPATHY

DRUGS

Aspirin	**Irreversible inhibition of the cyclo-oxygenase**
Clopidogrel *(Plavix®)*	**Irreversible binding of metabolite to ADP receptors type $P2Y_{12}$ on platelets**
Prasugrel *(Efient ®)*	
Ticagrelor *(Brilique ®)*	**Reversible antagonist of ADP receptors type $P2Y_{12}$ on platelets**
Abciximab *(ReoPro®)*	**Fab fragment of humanized chimeric antibody against glycoprotein IIb-IIIa (GP) receptors**
Eptifibatide *(Integrilin®)*	**Reversible inhibition GPIIb-IIIa receptors**
Tirofiban *(Agrastat ®)*	

RENAL FAILURE

PARAPROTEINEMIA

MYELOPROLIFERATIVE NEOPLASM OR MYELODYSPLASTIC SYNDROME

HEREDITARY THROMBOPATHY

THROMBASTHENIA OR GLANZMANN DISEASE

- Autosomal recessive transmission
- GP IIb-IIIa deficiency
- Pathological aggregation tests with ADP, adrenalin, collagen and arachidonic acid
- Normal aggregation on ristocetin *(primary phase)*
- Platelet count within normal range
- Absence of morphological anomaly

STORAGE POOL DISEASE

- Anomalies of dense granules *(ADP deficiency)*
- Pathological aggregation on ADP, adrenalin and collagen and frequently with arachidonic acid
- Platelet count within normal range
- Absence of morphological anomaly on electronic microscopy

BERNARD-SOULIER SYNDROME

- Autosomal recessive transmission *(rare dominant variant)*
- GP Ib / IX / V deficiency
- Absence of aggregation on high concentration ristocetin
- Thrombocytopenia of variable importance
- Presence of giant platelets

GRAY PLATELET SYNDROME

- Anomalies of α granules
- Platelet aggregation tests usually abnormal with ADP and collagen
- Thrombocytopenia of variable importance
- Giant, agranular platelets, of gray color on blood smear
- Absence of normal α granules and vacuolization of platelets on electronic microscopy

THROMBOCYTOPENIA

DEFINITION

Platelet count < 150 G / L

HEMORRHAGIC RISK

(In case of normal platelet function)

Low if platelet count in range of 50 to 150 G / L

High by platelet count < 20 G / L

SOME RULES OR RECOMMENDATIONS

Every thrombocytopenia has to be controlled on a blood smear *(exclusion of pseudothrombocytopenia due to EDTA anticoagulation of the probe)*

If platelet count < 50 G / L, measure of occlusion time (PFA-100™ or PFA-200™) is useless

Anemia (Hct < 30-35%) may disturb measure of occlusion time (PFA-100™ or PFA-200™)

If platelet functions are correct, the occlusion time on PFA-100™ (or PFA-200™) becomes prolonged if platelet counts < 100 G / L. Platelet count at 70 G / L with normal occlusion time does not allow exclusion of hemorrhagic risk in case of surgical procedure

At similar platelet levels the hemorrhagic risk is higher in case of "central" thrombocytopenia than in thrombocytopenia of "peripheral" origin

THROMBOCYTOPENIA (2)
IN THE SETTING OF BICYTOPENIA OR PANCYTOPENIA

Hypersplenism *(e.g. severe hepatic failure)*

Bone marrow dysfunction

Aplasia

Infiltration : **Myeloid or lymphoid neoplasm, osteomedullary cancer metastasis**

Dysplasia : **Reversible** *(Vitamin B_{12} or folate deficiency)*

Refractory *(Myelodysplastic syndrome)*

Fibrosis

Reduction of thrombopoietin synthesis *(e.g. severe hepatic failure)*

SOLITARY THROMBOCYTOPENIA

	CENTRAL	PERIPHERAL
Megakaryocytes	⇘	**Usually** ⇗
Mean platelet volume (MPV[1])	⇘ [2]	⇗
Etiology	**Thiazide** **Alcohol**	*(cf. p. 229-231)*

[1] MPV : Mean Platelet Volume ⚠ *EDTA anticoagulation of probe increases platelet size proportionally to delay between sampling and analyzis*

[2] Frequently increased in myeloproliferative neoplasm and myelodysplastic syndrome

SOLITARY PERIPHERAL THROMBOCYTOPENIA
NON IMMUNOLOGICAL

BY ANOMALY OF PLATELET DISTRIBUTION

Hypersplenism

BY PLATELET DESTRUCTION

Alcohol
Disseminated Intravascular Coagulation (DIC)
Extracorporeal circulation
Thrombotic Thrombocytopenic Purpura (TTP)[1]
Hemolytic Uremic Syndrome (HUS)[2]
HELLP[3] syndrome *(10% of preeclampsias)*
Renal transplant rejection
Allogeneic stem cell or bone marrow transplantation

[1] ***TTP :*** ***Thrombotic Thrombocytopenic Purpura***
[2] ***HUS :*** ***Hemolytic Uremic Syndrome***
[3] ***HELLP : Hemolysis, Elevated Liver function tests, Low Platelets*** *(in pregnancy)*

SOLITARY PERIPHERAL THROMBOCYTOPENIA (2)
IMMUNE

PRIMARY

Primary immune thrombocytopenia (Primary ITP), *cf. next page*

SECONDARY

Due to autoantibody or immune complexes

Drugs : Quinine

Heparin : Heparin-induced thrombocytopenia (HIT[1])

Type I : Early onset thrombocytopenia (< 24 h) and transient

Type II : 0.5-5% of patients treated by UFH[2]

Thrombocytopenia onset on treatment day 4 to 20

Thrombotic complications

Presence of anti-PF4[3]-Heparin (IgG) antibodies

Infection *(Helicobacter Pylori, hepatitis C, HIV, CMV, varicella, herpes zoster, malaria)*

Autoimmune disease *(SLE[4], Evans syndrome[5])*

Common variable type immune deficiency

Lymphoid neoplasm, cancer

Bone marrow / hematopoietic stem cell transplantation

Due to alloantibody

Neonatal thrombocytopenia

Posttransfusion purpura

[1] HIT : Heparin Induced Thrombocytopenia
[2] UFH : Unfractionated Heparin
[3] PF4 : Platelet Factor 4
[4] Systemic lupus erythematosus
[5] Autoimmune hemolytic anemia and thrombocytopenia

PRIMARY IMMUNE THROMBOCYTOPENIA (Primary ITP[1])

Acquired solitary thrombocytopenia (platelets < 100 G / L) **of immunological origin**

Antibodies directed against platelets and megakaryocytes, probable ↘ of thrombopoietin (TPO)

Diagnosis by exclusion of all other causes of thrombocytopenia

Clinical presentation :

Children : **Often preceded by viral infection**
Course usually benign with frequent spontaneous remission

Adults : **Persisting thrombocytopenia, often relapsing or chronic**
Depending on duration : **Newly diagnosed : ≤ 3 months**
Persistent : 3-12 months
Chronic : > 12 months

Bone marrow examination :

Age > 60 : Exclusion of myelodysplastic syndrome
Age < 60 : If signs of neoplasm or systemic disorder
Treatment refractoriness, relapse < 6 months
Prior to splenectomy or other second line therapy

Treatment :

Minor bleeding — **Prednisone 1-2 mg / kg qd orally, Dexamethasone 40 mg orally for 4 d**

Major bleeding — **Prednisone orally or Methyprednisolone 125-1'000 mg IV, d 1-5**
Immunoglobulins IV : 0.4 g / kg d 1-5 or 1 g / kg, d 1-2
If necessary platelet transfusion(s)

Refractory ITP — **Splenectomy**
Rituximab, TPO receptor agonists *(Romiplostim, Eltrombopag)*
Azathioprine, Micophenolate mofetil, Danazol, Cyclosporin A,
Cyclophosphamide, Alemtuzumab *(humanized anti-CD52),*
combined chemotherapy, Etanercept *(TNF-α inhibitor),* **allogeneic HST**

[1] **ITP** : **I**mmune **T**hrombocyto**P**enia

INVESTIGATION OF THROMBOCYTOPENIA

Complete blood count

Blood smear examination

- **Pseudothrombocytopenia ?**
- **RBC fragmentation** *(schistocytes)* **?**
- **Toxic changes of neutrophils ?**
- **Lymphocyte stimulation ?**
- **Absolute lymphocytosis ?**
- **Erythroblastosis and / or myelocytosis ?**
- **Parasites ?**

Complete coagulation tests with search for coagulation activation (DIC)

Bone marrow examination *(cytology and histology)*

Direct Coombs test *(antiglobulin test)*

Viral serology *(HIV, HCV, EBV, CMV)*

SLE[1] serology

Thyroid function tests

Helicobacter pylori screening *(to be considered in refractory or relapsing Primary ITP[2])*

Anti-HLA antibodies

Antiplatelet antibodies *(this test is frequently difficult to carry out, as it needs a platelet count rarely high enough at diagnosis)*

[1] **Systemic lupus erythematosus**
[2] **ITP : Immune ThrombocytoPenia**

HEMORRHAGIC SYNDROME
SECONDARY HEMOSTASIS (COAGULATION)

CONSTITUTIONAL ANOMALIES

Hemophilias (factors VIII, IX), von Willebrand disease *(cf. p. 234-237)*
Fibrinogen, factors II, V, VII, X, XI, XIII deficiencies

ACQUIRED ANOMALIES

Hepatocellular failure *(deficiencies of fibrinogen, factors II, V, VII, X)*
Vitamin K deficiency *(deficiencies of factors II, VII, IX, X)*
Disseminated intravascular coagulation (DIC)

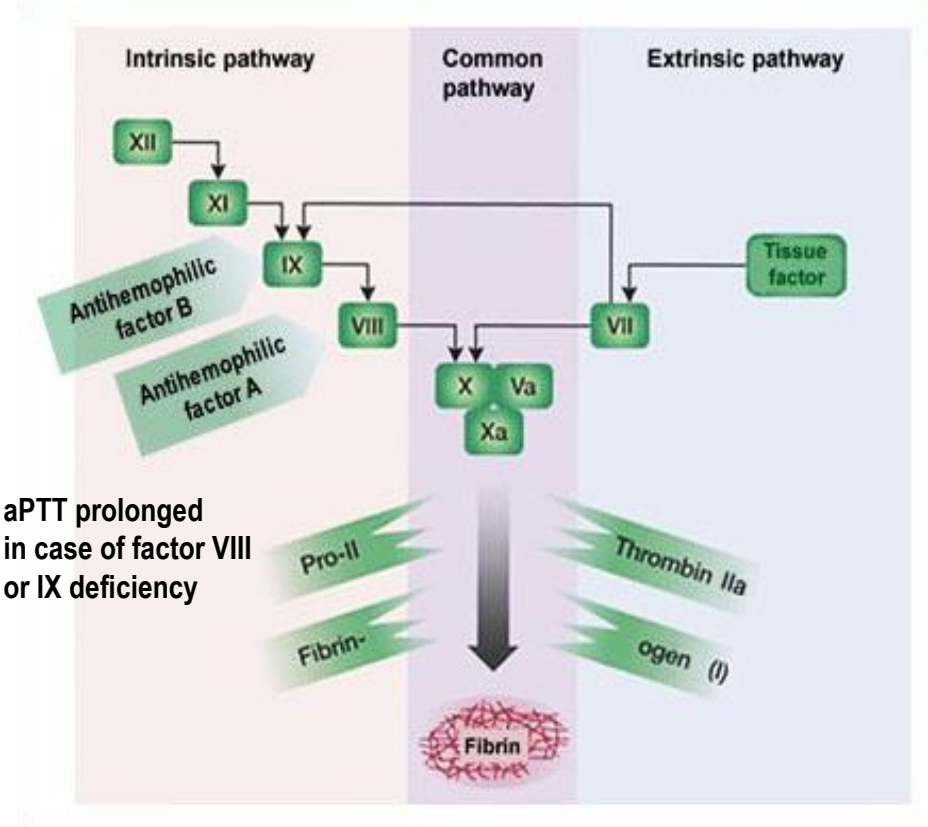
- **Bacterial or parasitic infections**
- **Cancer** *(lung, pancreas, prostate)*
- **Acute leukemia, particularly Acute Promyelocytic Leukemia, t(15;17)(q24;q21)**
- **Obstetrical complications**
  - **Amniotic liquid embolism**
  - **Placental retention**
  - **Eclampsia**
  - **Septic abortion**
- **Invasive surgery**
- **Extended burns**
- **Transfusion complications**
- **Vascular malformations** *(Kasabach-Merritt syndrom)*

Coagulation inhibitors (circulating anticoagulants)

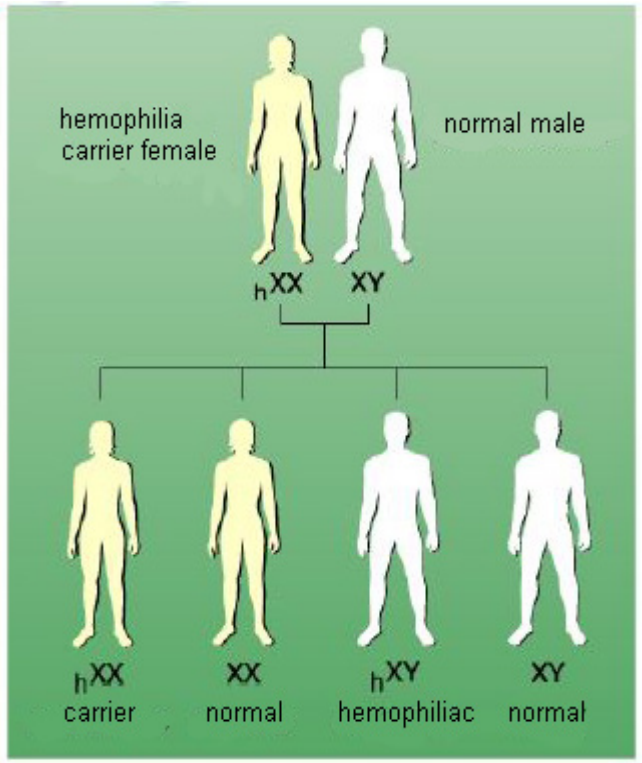
Alloaantibodies against factor VIII *(5-10% of hemophilia patients)*

Autoantibodies against factor VIII *(acquired hemophilia A)* **: pregnancy, postpartum, rheumatoid arthritis, lupus erythematosus, cancer, drugs**

HEMOPHILIA



aPTT prolonged
in case of factor VIII
or IX deficiency



Recessive X-linked transmission

Absence of familial context in 30% of hemophilia patients : de novo mutation

Risk for offsprings of a couple of a carrier woman and a normal man :

50% of the sons with hemophilia
50% of daughters are carriers

HEMOPHILIA (2)

INCIDENCE

Hemophilia A : 1 / 10'000, 5 x more frequent than hemophilia B

HEMOPHILIA	FACTOR LEVEL (%)	HEMORRHAGIC SYNDROME
Light[1]	5 – 40	Surgery Dental extraction Important trauma / injury
Moderate	1 – 5	Light trauma *(e.g. sport)*
Severe[2]	< 1%	Several bleeding episodes / month Frequent spontaneous hemorrhages Frequent hemarthrosis episodes

TREATMENT

Analgesia : ***Paracetamol, tramadol, codeine, opiates***

⚠ ***Aspirin and NSAID[3] absolutely contraindicated except Celecoxib***

Factors concentrates or recombinant factors. Desmopressin (DDAVP) : light forms

Factor VIII : distribution ½-life 4 hours, plasmatic ½-life 12 hours
Factor IX : distribution ½-life 2 hours, plasmatic ½-life 24 hours

Orthopedic surgery : hemarthrosis

In case of inhibitors : recombinant factor VIIa *(NovoSeven®)*, **Factor Eight Inhibitor By-passing Activity** *(FEIBA NF®)*

[1] Carrier female may have occasionally light symptoms
[2] Females may only have severe symptoms if the father is hemophiliac and the mother carrier
[3] NSAID : Non Steroidal Antiinflammatory Drugs

VON WILLEBRAND DISEASE

Quantitative or qualitative anomaly of von Willebrand factor

The most common constitutional hemorrhagic disorder *(incidence ~ 1% of whole population)*

Transmission autosomal, dominant or recessive

Symptomatic disease in ~ 1% of patients

6 different types of disease; type 1 is the most frequent *(75% of cases)*

Mucosal and cutaneous bleeding *(epistaxis, menorrhagia)*

Biological signs : PFA-100™ or PFA-200™ prolonged[1], PT normal, aPTT prolonged
⇘ Factor VIII, ⇘ Factor von Willebrand *(antigen and activity)*

Occasional acquired form : associated with lymphoid, plasmacytic, myeloproliferative neoplasms, etc.

[1] Replaces bleeding time if analyzer available

VON WILLEBRAND DISEASE (2)

CLASSIFICATION

TYPE	TRANSMISSION	FvW ACTIVITY	RIPA[1]	FvW MULTIMERS
TYPE 1 (quantitative ↘)	**AD[2]**	**± severe ↘**	**↘**	**uniform ↘ / all sizes present**
TYPE 2 (qualitative anomaly)				
2A	**AD[2]** (possibly AR[3])	**↘**	**↘**	**↘ of large multimers**
2B	**AD[2]**	**↘**	**↗[4]**	**↘ of large multimers**
2M	**AD[2]** (possibly AR[3])	**↘**	**↘**	**uniform ↘ / all sizes present**
2N	**AR[3]**	**⇔**	**⇔**	**⇔**
TYPE 3 (severe)	**AR[3]**	**↘↘ - Ø**	**↘↘ - Ø**	**undetectable**

[1] RIPA : Ristocetin-Induced Platelet Aggregation
[2] AD : Autosomal Dominant
[3] AR : Autosomal recessive
[4] At Ristocetin concentration lower than 0.6 mg/mL

Modified from : The National Heart, Lung and Blood Institute. The Diagnosis, Evaluation and Management of Von Willebrand Disease, Bethesda, MD; National Institutes of Health Publication 2007, 08-5832.

TREATMENT

Desmopressin *(DDAVP = 1-**D**eamino-8-**D**-**A**rginine **V**aso**P**ressin : Octostim®, possibly Minirine®)*, **IV, SC or intranasal**
Increases factor von Willebrand secretion as of factor VIII. Useful only in type 1 disease

Factor VIII and factor von Willebrand concentrates *(e.g. Haemate P®, Wilate®),* **von Willebrand factor concentrate** *(Willfact®)*

Antifibrinolytics : tranexamic acid *(Cyklokapron®)*

Topical preparations

Recombinant factor VIII preparations do not contain von Willebrand factor

DDAVP TEST

Allows to asses in asymptomatic situation the efficacy of desmopressin application. In case of good response, Desmopressin will be used prophylactically prior to surgical procedure or dental extraction

THROMBOEMBOLIC DISEASE

VIRCHOW'S TRIAD : Stasis + vascular lesion(s) + blood hypercoagulability

ESSENTIAL RISK FACTORS

Arterial thrombosis

- Arterial hypertension
- Hyperlipemia, diabetes
- Smoking

Venous thrombosis

- **Stasis** *(bed rest, lower limb immobilization, dehydration, ⇗ plasmatic viscosity, varicose veins)*
- **Surgery** *(in particular hip and abdomen)*
- **Trauma**
- **Pregnancy and post-partum**
- **Estrogens, oral contraceptives**
- **Cancer**
- **Behçet disease**
- **Constitutional coagulation anomalies *(Thrombophilia)***

(cf. table)

Arterial or venous thrombosis

- **Myeloproliferative neoplasm**
- **Heparin induced thrombocytopenia (HIT)**
- **Hyperhomocysteinemia**
- **Antiphospholipid antibodies syndrome** *(cf.p.: 247-248)*
  - **Paradoxically prolonged PT or aPTT in a situation of :**
    - **Venous or arterial thrombosis, of recurrent fetal losses or of other disorders of pregnancy**
    - **Sometimes in the context of systemic disorders as lupus erythematosus** *("lupus anticoagulant")*, **infection, neoplasia, drugs**

THROMBOPHILIA
PREVALENCE AND RELATIVE RISK INCREASE OF VENOUS THROMBOEMBOLIC DISORDERS

	Mutation F5 R506Q Facteur V Leiden[1]	Mutation F2 G20210A Prothrombin	Lupus anticoagulant	Anticardiolipin antibodies	Anti-β2-glycoprotein antibodies	Antithrombin deficiency	Protein C deficiency	Protein S deficiency	Hyperhomo-cysteinemia
			Antiphospholipid antibodies						
Prevalence in general population	3 - 7 %	0.7 - 4 %	1 - 8 %	5 %	3.4 %	0.02 %	0.2 %	0.03 - 0.13 %	5 - 10 %
Relative risk od first event	5 - 7	2 - 3	3 - 10	0.7	2.4	15 - 20	15 - 20	15 - 20	1.5 - 2.5
Relative risk of relapse	1.4	1.4	2 - 6	1 - 6	-	1.9 - 2.6	1.4 - 1.8	1 - 1.4	2.5

[1] Heterozygote carriers

D'après : G. Abetel et A. Angellilo-Scherrer, Rev Med Suisse 2014; 10 : 1028-1033.

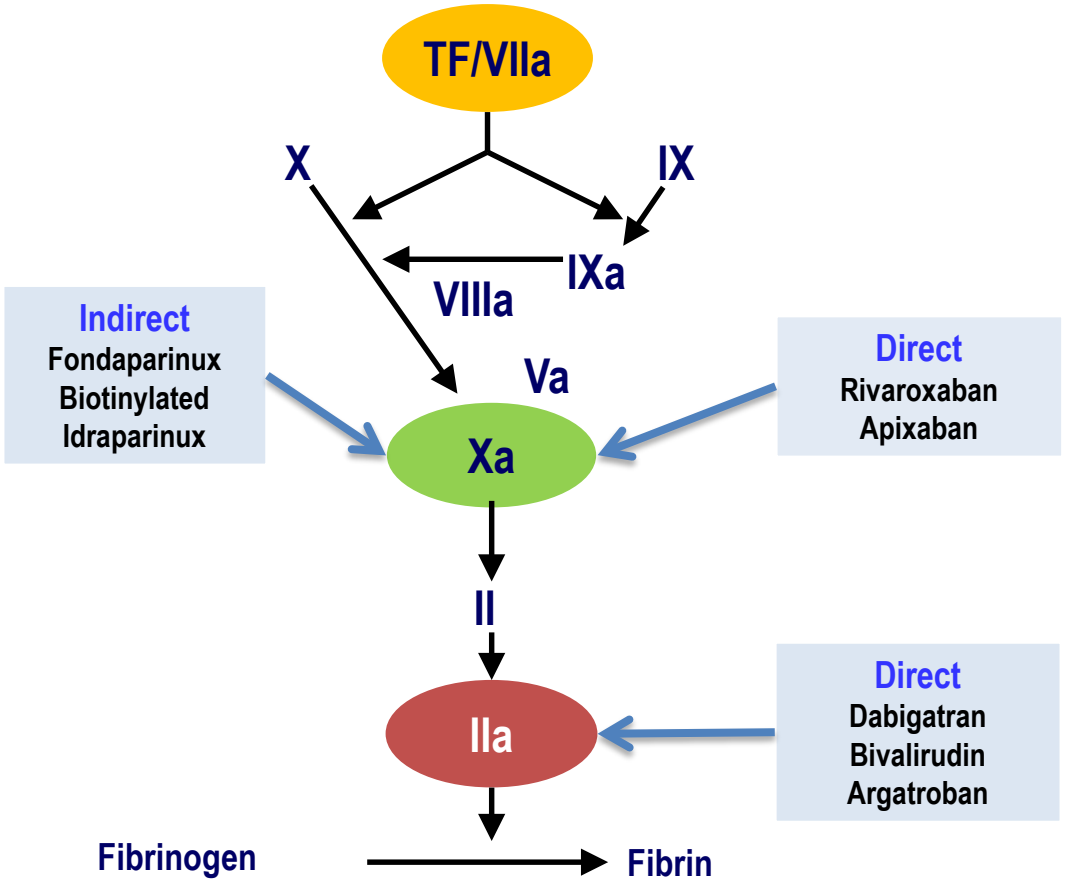
THROMBOEMBOLIC DISEASE (2)
DIAGNOSTIC TESTS OF THROMBOPHILIA

Baseline tests : PT, aPTT, CBC (Complete Blood Count)

Risk factors	Screening tests	Confirmation tests	Do not test in following situations :
Antithrombin deficiency	Antithrombin activity	Antigenic antihrombin	UFH[1], LMWH[2], liver failure, DIC[3], nephrotic syndrome
Protein C deficiency	Protein C activity	Antigenic and chromogenic protein C	AVK[4], vitamin K deficiency, liver failure, DIC[3]
Protein S deficiency	Free Protein S	Total and coagulant protein S	AVK[4], vitamin K deficiency, liver failure, DIC[3], pregnancy, oral contraception, hormone replacement therapy
Facteur V Leiden	Activated protein C resistance	Factor V Leiden (PCR)	
Prothrombin mutation	Prothrombin mutation (PCR)		
Lupus anticoagulant	PTT-LA[5] et dRVVT[6] Diagnosis if 1 test positive		Anticoagulation : Heparin affect PTT-LA[5] and AVK[4] prolongs dRVVT[6] ≤ 12 weeks after acute thromboembolic event
Anticardiolipin antibodies	ELISA for IgG and IgM isotypes		< 12 weeks after acute thromboembolic event
Anti-β_2-glycoprotein I antibodies	ELISA for IgG and IgM isotypes		< 12 weeks after acute thromboembolic event
Hyperhomocysteinemia	Fasting homocystein dosage		

[1] UFH : Unfractionated heparin
[2] LMWH : Low molecular weight heparin
[3] DIC : Disseminated intravascular coagulation
[4] AVK : Anti-vitamin K
[5] PTT-LA : PTT-Lupus sensitive
[6] dRVVT : Diluted Russel venom test

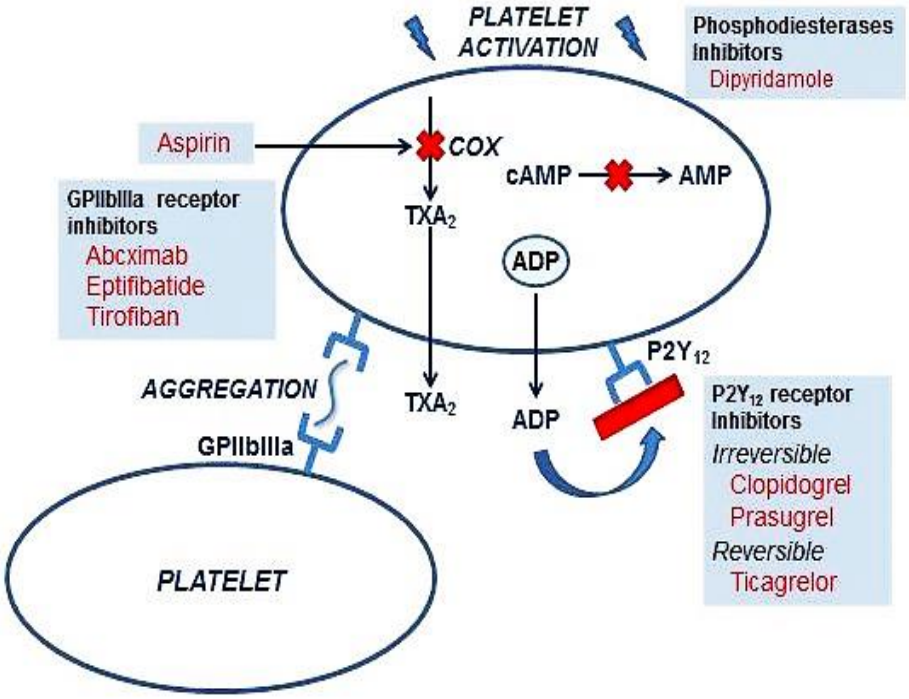
TARGETS OF ANTICOAGULANTS



- Inhibition by antithrombin of 1 molecule of FXa can block the generation of **50 thrombin molecules**[1]
- 1 molecule of FXa can generate over **1'000 thrombin molecules**[2]

[1] *Wessler S. & Yan E.T. : On the antithrombotic action of heparin. Thrombo Diath Haemorrh 1974; 32 : 71-78.*
[2] *Mann K.G. et al. : What is all that thrombin for ? J Thromb Haemost 2003; 1 : 1504-1514.*

THROMBOEMBOLIC DISEASE
TREATMENT AND PREVENTION



Aspirin **blocks synthesis of thromboxane A_2 by irreversible acetylation of cyclooxygenases (COX)**

Clopidogrel *(Plavix®)* ***and Prasugrel*** *(Efient®)* **cause irreversible inhibition of $P2Y_{12}$ ADP receptor**

Ticagrelor *(Brilique®)* **is a reversible antagonist of $P2Y_{12}$ ADP receptor**

Dipyridamole **increases platelet cyclic AMP through inhibition of phosphodiesterases**
(Asasantine® : dipyridamole + aspirin)

Abciximab *(ReoPro®)* **is an antagonist of GP IIb/IIIa receptor**

Etifibatide *(Integrilin®)* ***and Tirofiban*** *(Agrastat®)* **reversibly inhibit GP IIb-IIIa receptor**

THROMBOEMBOLIC DISEASE
TREATMENT AND PREVENTION (2)

HEPARINS, THROMBIN AND FACTOR Xa INHIBITORS

Heparins **Unfractioned :** *Liquemin®, Calciparin®*	**Fixation and activation of AT[1], inhibition of factors Xa and IIa, inhibition of platelets, interaction with endothelium**
Low molecular weight : **Nadroparin** *(Fraxiparin® or Fraxiforte®),* **Dalteparin** *(Fragmin®),* **Enoxaparin** *(Clexane®),* **Certoparin** *(Sandoparin®)*	**Fixation and activation of AT[1], inhibition of factor Xa, very low inhibition of factor IIa, absence of platelet inhibition, few interactions with endothelium**
Danaparoid *(Orgaran®)*	**High affinity for AT III[1], anti-Xa activity, no effect on platelets**
Pentasaccharide : Fondaparinux *(Arixtra®)*	**Fixation and activation of AT[1], anti-Xa activity**
Hirudin analogues : Bivalirudin *(Angiox®)*	**Direct inhibition of thrombin**
Argatroban *(Argatra®)* **Dabigatran** *(Pradaxa®)*	
Rivaroxaban *(Xarelto®)* **Apixaban** *(Eliquis®)*	**Direct inhibition of factor Xa**

[1] **AT : Antithrombin**

THROMBOEMBOLIC DISEASE
TREATMENT AND PREVENTION (3)

VITAMIN K ANTAGONISTS

Therapeutic agents

Acenocoumarol *(Sintrom®)*
(½ life : 8-11 hours)

Phenprocoumon *(Marcoumar®)*
(½ life : 32-46 hours)

Inhibition of γ-carboxylation of vitamin K dependent factors (FII, FVII, FIX, FX)

Biological monitoring of treatment with vitamin K antagonists (INR : International Normalized Ratio)

INR = (PT patient *[seconds]* / PT control *[seconds]*)^{ISI}

ISI = International Sensitivity Index : sensitivity index of employed reagent compared to international reference reagent

Therapeutical ranges

	Low limit	Target	High limit
Primary and secondary prevention of venous thromboembolic disease	2.0	2.5	3.0
Mechanical prosthetic cardiac valves[1]	2.5	3.0	3.5

FIBRINOLYTIC AGENTS

Tissular plasminogen activator, t-PA *(Actilyse®)*, **Streptokinase** *(Streptase®)*, **Urokinase** *(Urokinase HS medac®)*

[1] *For more information, Whitlock R.P. et al. : Antithrombotic and Thrombolytic Therapy for Valvular disease : Antithrombotic Therapy and Prevention of Thrombosis : American College of Chest Physicians Evidence-Based Clinical Practice Guidelines (9th Edition). Chest 2012; 141 : e576S-600S.*

VENOUS THROMBOEMBOLIC DISEASE (VTED)
ANTICOAGULATION GUIDELINES

INITIAL TREATMENT *(Options, depending on situation)*

UNFRACTIONATED HEPARIN[1,2]	LOW MOLECULAR WEIGHT HEPARIN[2]	FONDAPARINUX (Arixtra®)	RIVAROXABAN (Xarelto®)	APIXABAN (Eliquis®)
Bolus IV 80 UI / kg (2'500-5'000 UI) followed by 400-600 UI / kg / 24 h *(25'000-40'000 UI)* by continuous iv. perfusion To be prefered in case of severe renal failure	*e.g. : Enoxaparin (Clexane®)* : 2 mg / kg / 24 h in 2 SC inj. In elderly patients, by BW < 50 kg or > 100 kg : dosage of plasmatic anti-Xa activity after 2nd or 3d dose, 3-5 h after SC injection Caution by creatinin clearance < 30 mL / min	7.5 mg SC qd 5 mg by body weight (BW) < 50 kg, 10 mg if BW > 100 kg Contraindication : creatinin clearance < 30mL / min No control of platelet count needed	Treatment of DVT and PE : 15 mg orally 2x qd during 3 weeks (Treatment schedule has to be imperatively respected !) After 3 weeks, dosis reduction to 20 mg qd orally *(maintenance treatment)* Relapse prevention of VTED : 20 mg qd orally No switch to AVK necessary	10 mg 2x qd orally for 7 days followed by 5 mg 2x qd orally VTED relapse prevention : 2,5 mg 2x qd orally

MAINTENANCE TREATMENT

EARLY SWITCH TO ANTIVITAMIN K DRUGS *(Acenocoumarol : Sintrom®)*	DABIGATRAN (Pradaxa®) Thrombin inhibitor
3 mg qd orally from the first or second treatment day *(2 mg qd by age > 70 ans, BW < 50 kg or initial PT < 85%)* INR control after the first 2 doses By INR > 1.8 : ↘ dosis of 3d day By INR between 1.2 and 1.8 : same dosis on 3d day By INR < 1.2 : light dosis ↗ on 3d day Target : allow stopping of the in initial anticoagulation *(SC or IV)* < 5 days and / or after 2 consecutive INR at 24 h interval > 2.0	After initial treatment for at least 5 days (Heparin or Fondaparinux) : 2x 150 mg qd orallly VTED relapse prevention : 150 mg 2x qd

[1] Activated partial thromboplastin time (aPTT) controls must be 1.5 - 2.5 time over baseline value. Daily heparin dosis is consequently adapted

[2] Heparin administration has to be kept as short as possible *[↗ risk of heparin induced thrombocytopenia (HIT) with prolonged heparin treatment]*
Monitoring of platelet count : if HIT risk >1%, every 2-3 d from d 4 to d 14 (or at heparin stop if prior to d 14)
If HIT risk < 1%, no platelet count monitoring
In case of previous Heparin exposition : baseline platelet count at treatment begin, then 24 hours later if possible

VENOUS THROMBOEMBOLIC DISEASE (VTED)
ANTICOAGULATION GUIDELINES (2)

DURATION OF ANTICOAGULATION

	ANTI-VITAMIN K	ANTI-F Xa / ANTI-THROMBIN
Postoperative limited deep vein thrombosis of the leg, increased bleeding risk	6 weeks	3 months
Proximal deep vein thrombosis / Secondary pulmonary embolism	3 months	3 months
Deep vein thrombosis / Idiopathic pulmonary embolism	6-12 months *(or more if persisting risk factor without increased bleeding risk)*	6 months *(risk reevaluation in relation with expected benefit after this period*
Recurrent deep vein thrombosis and / or pulmonary embolism	Long term	

INDICATIONS OF NEW ANTICOAGULANTS

⚠ Antidotes in investigation

INDICATION	Rivaroxaban (Xarelto®)	Apixaban (Eliquis®)	Dabigatran (Pradaxa®)
PREVENTION OF VTED[3]	Major orthopedic procedures of lower extremities (hip or knee prosthetic replacement)	Adult patients : After scheduled operation for hip or knee prosthetic replacement	No indication
VTED[3] TREATMENT AND RELAPSE PREVENTION	Treatment of DVT[1] Prevention of DVT[1] and PE[2] recurrence	Treatment of DVT[1] and of PE[2] Prevention of DVT[1] and of PE[2]	Treatment of DVT[1] and of PE[2] Prevention of DVT[1] and of PE[2]
PREVENTION OF AIS[4] RELATED TO NON VALVULAR AF[8]	Prevention of AIS[4] and of SE[6] related to AF[8]	Prevention of AIS[4] and of SE[6] related to AF[8]	In patients with non valvular AF[8] associated with one or more of following risk factors : • Previous AIS[4], TIA[5] or SE[6] • LVEF[7] < 40% • Symptomatic cardiac failure ≥ class II NYHA[9] • Age ≥ 75 years • Age ≥ 65 years with one of following affections : diabetes, coronaropathy or arterial hypertension

[1] DVT : Deep Vein Thrombosis; [2] PE : Pulmonary embolism; [3] VTED : Venous thromboembolic Disease; [4] AIS : Acute Ischemic Stroke; [5] TIA : Transient Ischemic Attack; [6] SE : Systemic Embolism; [7] LVEF : Left Ventricular Ejection Fraction; [8] AF : Atrial Fibrillation; [9] NYHA : New York Heart Association

After : Swiss Drug Compendium 2015.

EFFECTS OF ANTICOAGULANTS ON COAGULATION TESTS

ANTICOAGULANT	TARGETS	aPTT	PT[2]	INR	TT	FIBRINOGEN	D-DIMERS	ANTI- Xa	ANTI-IIa
Vitamin K antagonists	II, VII, IX, X, protein C and S	⇗	⇘	⇗	⇔	⇔	⇔	⇔	⇔
Unfractionated heparin	IIa and Xa (AT-dependent)	⇗	⇔	⇔	⇗	⇔	⇔	⇗	⇗
Low molecular weight heparin	Xa (AT-dependent)	⇔	⇔	⇔	⇗	⇔	⇔	⇗	⇔
Dabigatran *(Pradaxa®)*	IIa[1]	⇗	⇘	⇗	⇗	⇔	⇔	⇔	⇗
Rivaroxaban *(Xarelto®)*	Xa[1]	⇗	⇘	⇗	⇔	⇔	⇔	⇗	⇔
Apixaban *(Eliquis®)*	Xa[1]	⇗	⇘	⇗	⇔	⇔	⇔	⇗	⇔
AT = antithrombin. Coagulation factors are mentioned by their roman numeral. «a» means «activated»									

[1] Free and bound form
[2] PT (Quick) expressed in %

After : Gavillet M., Angelillo-Scherrer A. Quantification of the anticoagulatory effet of novel anticoagulants and management of emergencies. Cardiovascular Medicine 2012;15 : 170-179.

ANTIPHOSPHOLIPID SYNDROME
DIAGNOSTIC CRITERIA

CLINICAL CRITERIA

VASCULAR THROMBOSIS	PREGNANCY DISORDERS
≥ 1 episode(s) of thrombosis (arterial, venous or of small vessels in any tissue or organ)	≥ 1 fetal death(s) at the 10th week og gestation at least ≥ 1 premature birth(s) before the 34th week of gestation due to eclampsia, pre-eclampsia or placental insufficiency ≥ 3 consecutive (pre-)embryonal losses before the 10th week of gestation

BIOLOGICAL CRITERIA

Lupus anticoagulant found at ≥ 2 occasions, at 12 weeks intervall

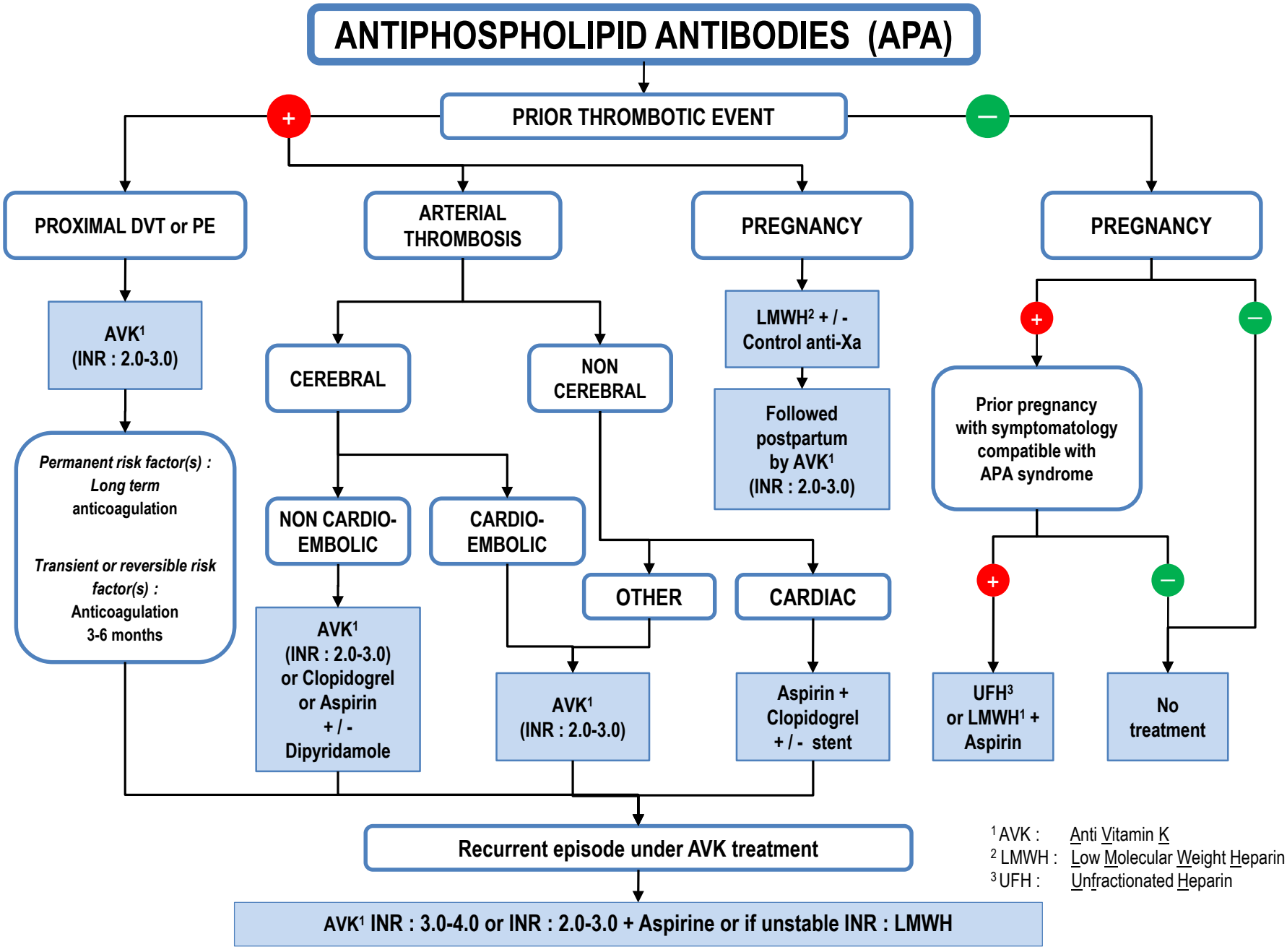
Anticardiolipin antibodies (IgG and / or IgM) present at medium or high titer[1] at ≥ 1 occasion, at 12 weeks intervall

Anti-β_2-glycoprotein I antibodies present at medium or high titer[1] at ≥ 2 occasions, at 12 weeks intervall

DIAGNOSIS : at least 1 clinical criterion + 1 biological criterion

After : G. Abetel et A. Angellilo-Scherrer, Rev Med Suisse, 2014 : 10 : 1028-1033.

[1] Titer > 40 or above the 99th percentile

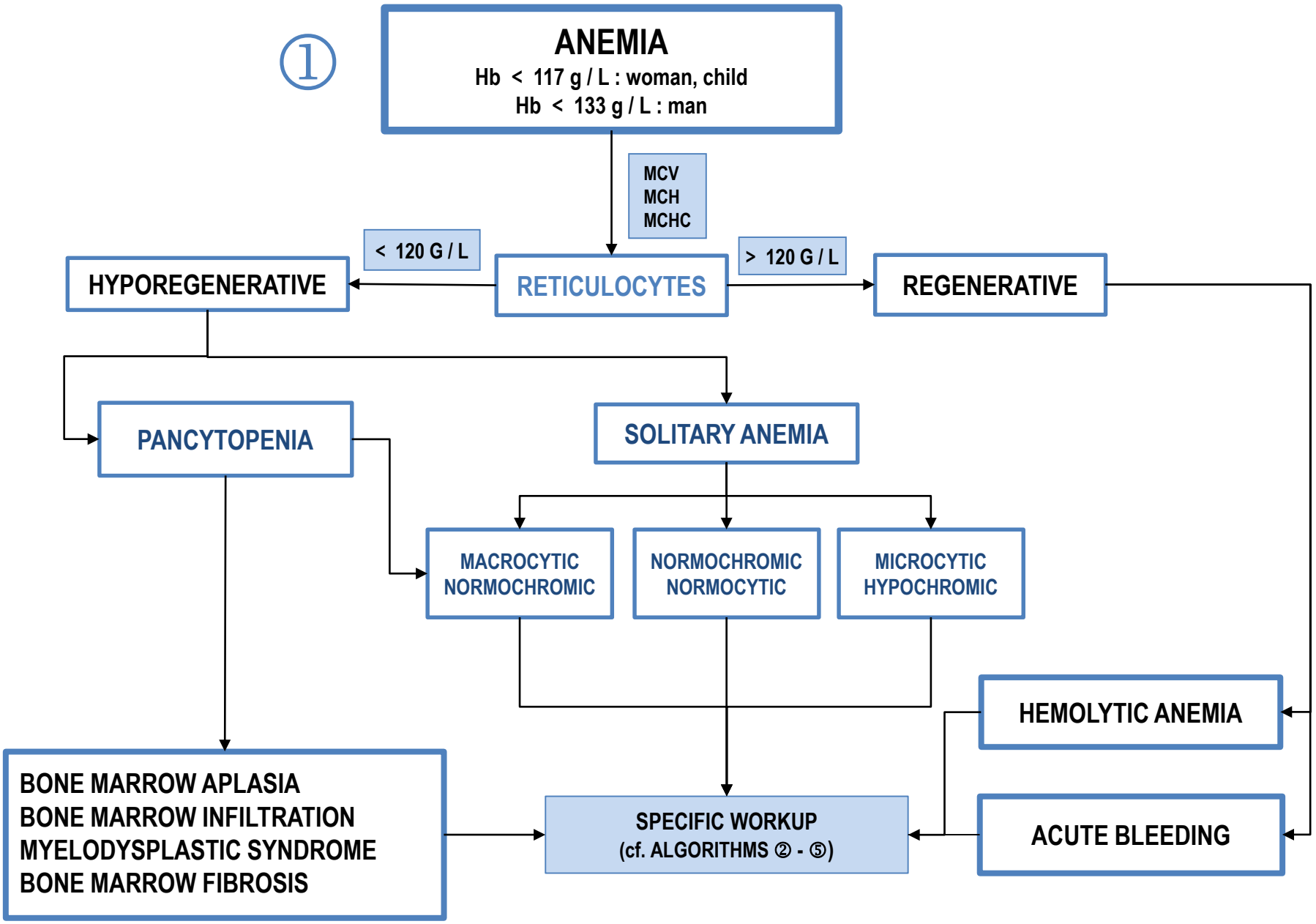


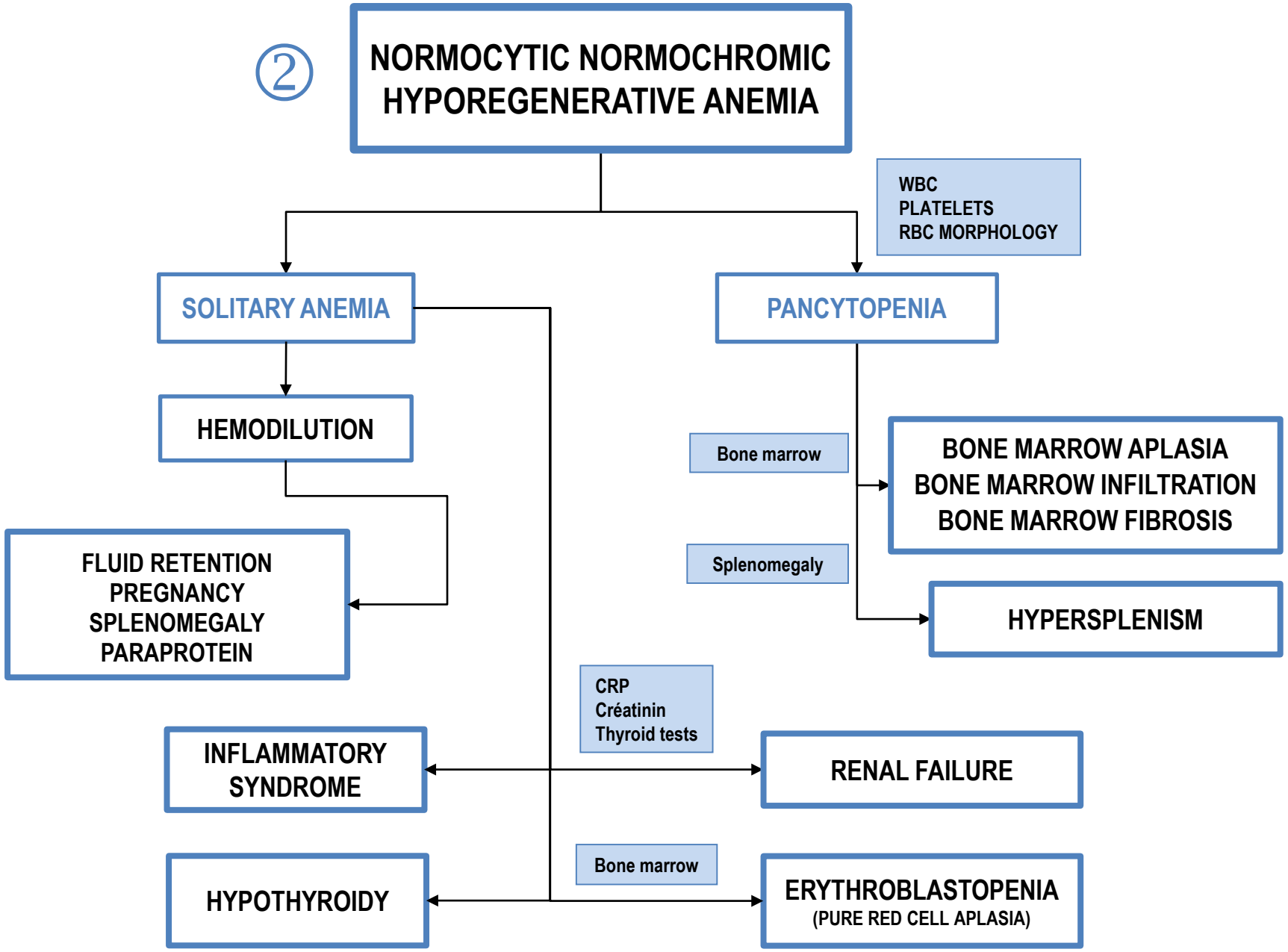
[1] AVK : Anti Vitamin K
[2] LMWH : Low Molecular Weight Heparin
[3] UFH : Unfractionated Heparin

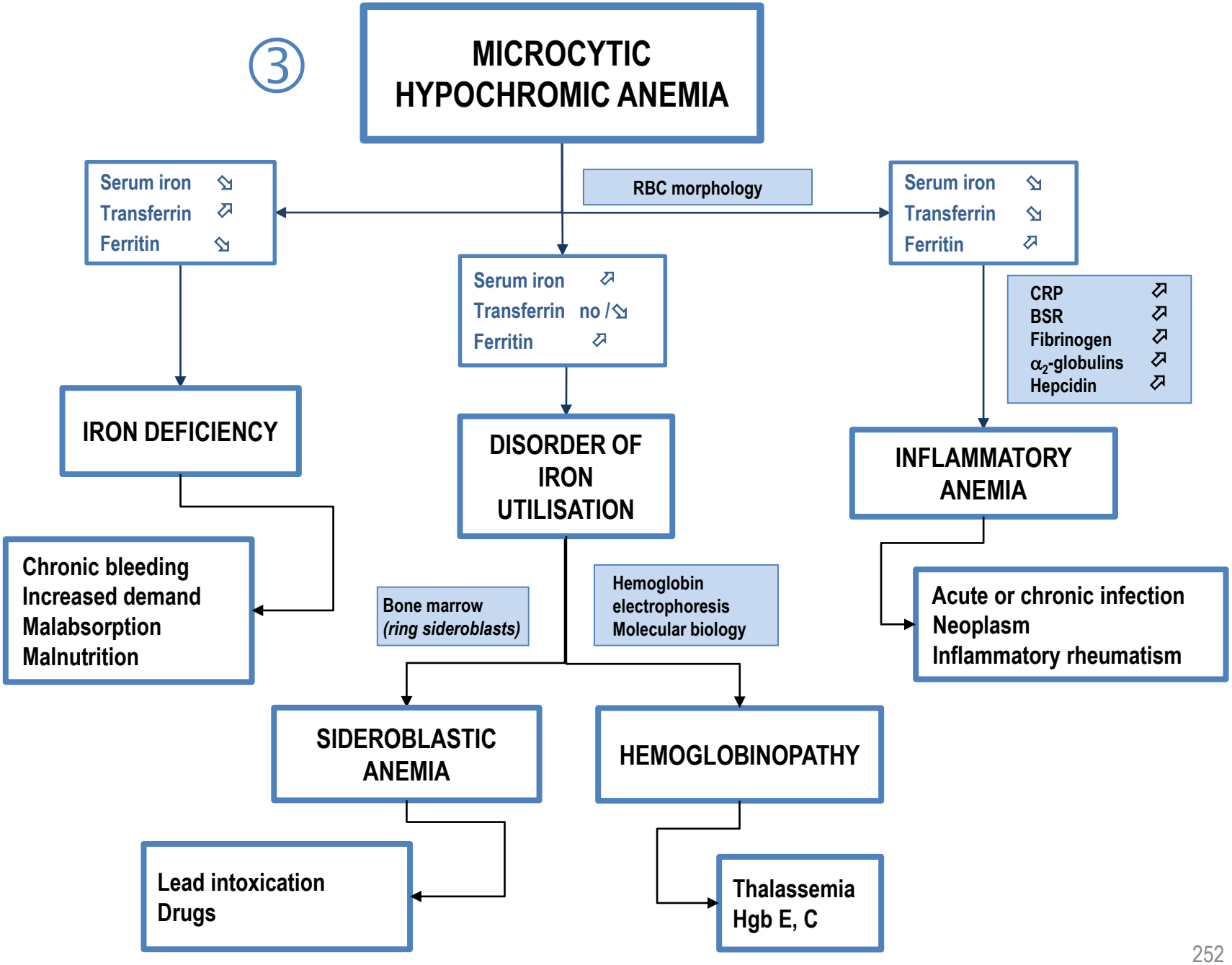
Modified from Giannakopoulos B., Krilis S.A.: How I treat the antiphospholipid syndrome. Blood 2009; 114 : 2020-2030.

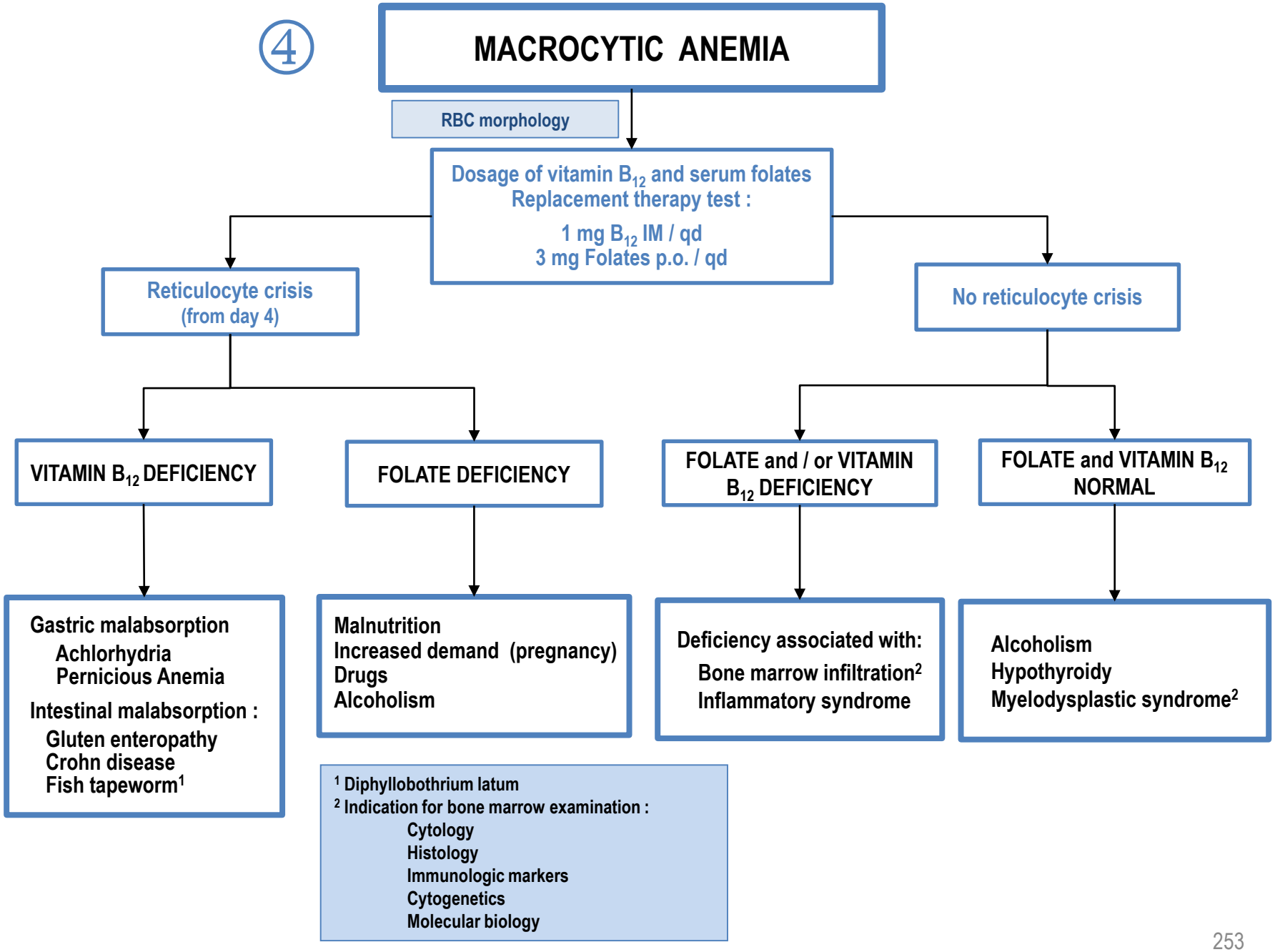
Part 4

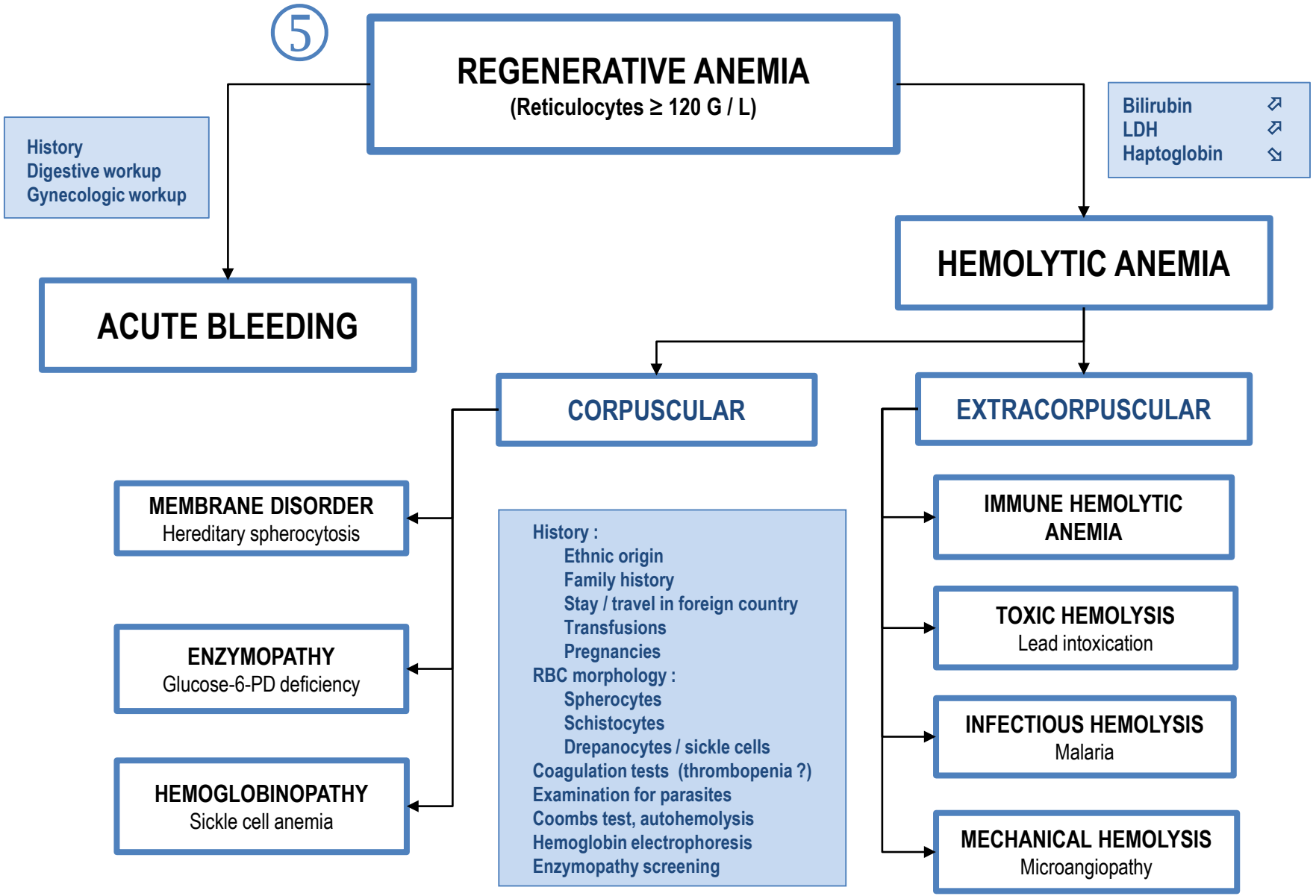
DIAGNOSTIC ALGORITHMS

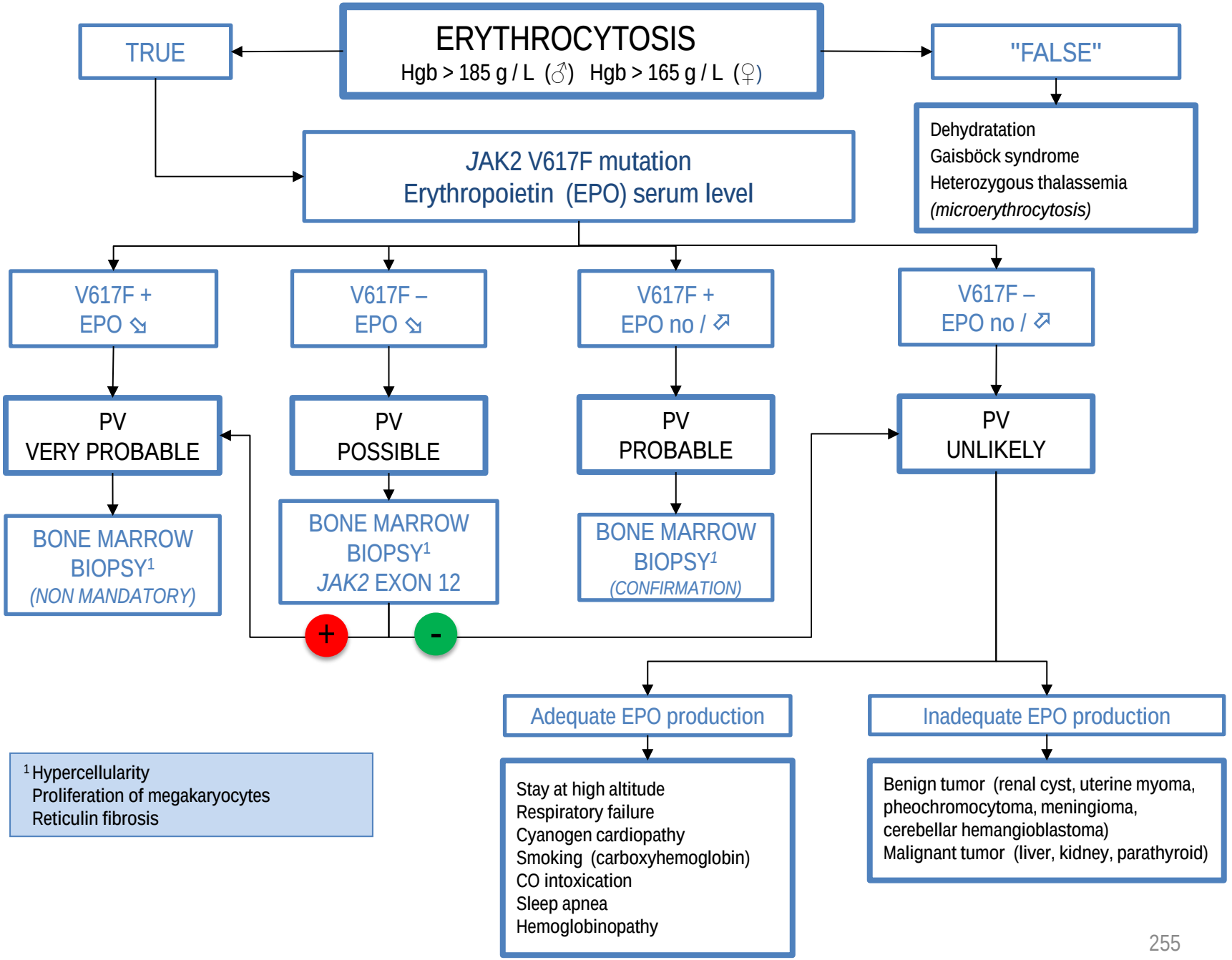

①
ANEMIA
Hb < 117 g / L : woman, child
Hb < 133 g / L : man
MCV
MCH
MCHC
< 120 G / L
> 120 G / L
HYPOREGENERATIVE
RETICULOCYTES
REGENERATIVE
PANCYTOPENIA
SOLITARY ANEMIA
MACROCYTIC
NORMOCHROMIC
NORMOCHROMIC
NORMOCYTIC
MICROCYTIC
HYPOCHROMIC
HEMOLYTIC ANEMIA
BONE MARROW APLASIA
BONE MARROW INFILTRATION
MYELODYSPLASTIC SYNDROME
BONE MARROW FIBROSIS
SPECIFIC WORKUP
(cf. ALGORITHMS ② - ⑤)
ACUTE BLEEDING

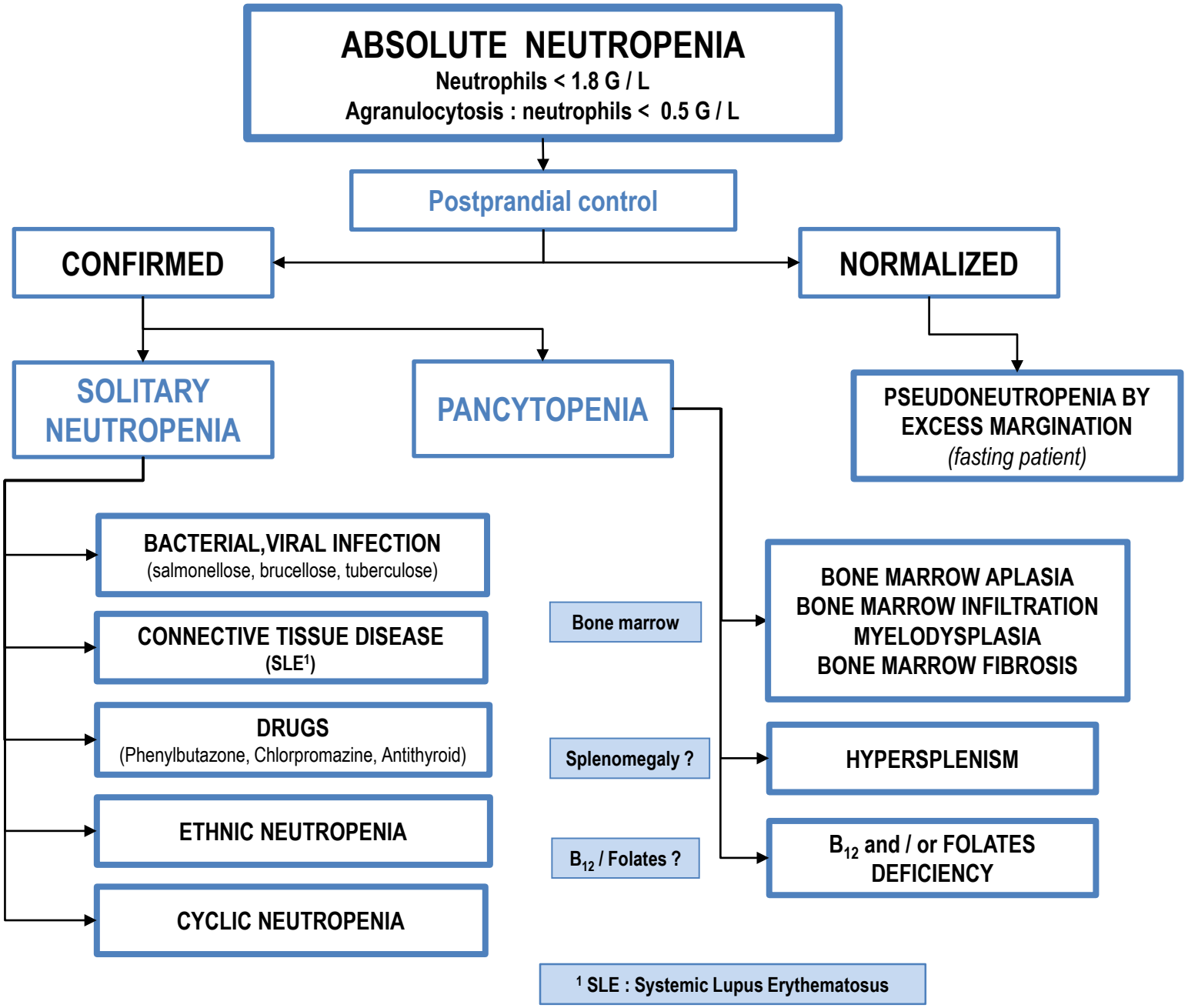

②
NORMOCYTIC NORMOCHROMIC HYPOREGENERATIVE ANEMIA
WBC
PLATELETS
RBC MORPHOLOGY
SOLITARY ANEMIA
PANCYTOPENIA
HEMODILUTION
Bone marrow
BONE MARROW APLASIA
BONE MARROW INFILTRATION
BONE MARROW FIBROSIS
FLUID RETENTION
PREGNANCY
SPLENOMEGALY
PARAPROTEIN
Splenomegaly
HYPERSPLENISM
CRP
Créatinin
Thyroid tests
INFLAMMATORY SYNDROME
RENAL FAILURE
Bone marrow
HYPOTHYROIDY
ERYTHROBLASTOPENIA
(PURE RED CELL APLASIA)

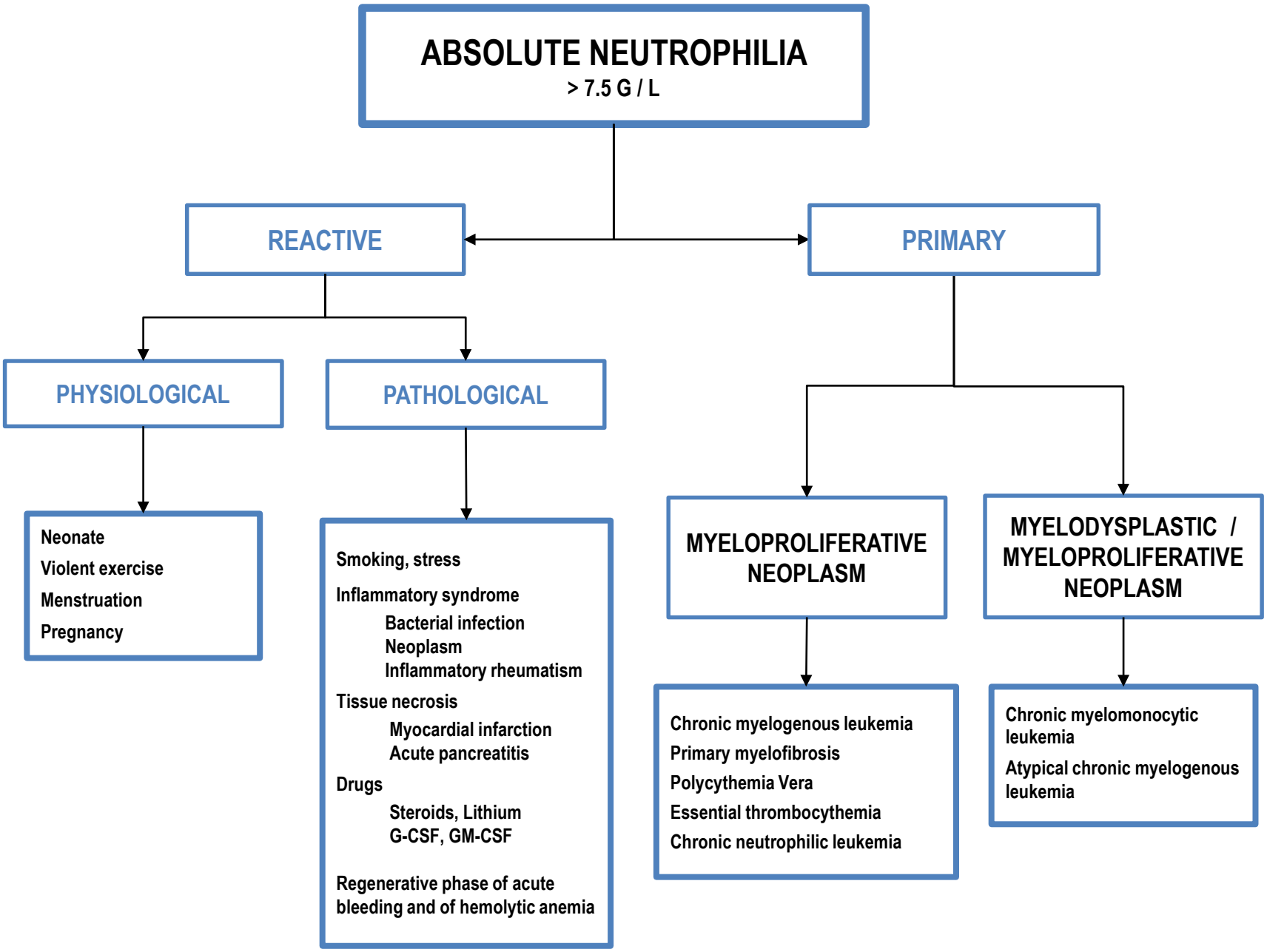

③
MICROCYTIC HYPOCHROMIC ANEMIA
RBC morphology
Serum iron ↘
Transferrin ↗
Ferritin ↘
Serum iron ↗
Transferrin no /↘
Ferritin ↗
Serum iron ↘
Transferrin ↘
Ferritin ↗
CRP ↗
BSR ↗
Fibrinogen ↗
α2-globulins ↗
Hepcidin ↗
IRON DEFICIENCY
DISORDER OF IRON UTILISATION
INFLAMMATORY ANEMIA
Chronic bleeding
Increased demand
Malabsorption
Malnutrition
Bone marrow
(ring sideroblasts)
Hemoglobin electrophoresis
Molecular biology
Acute or chronic infection
Neoplasm
Inflammatory rheumatism
SIDEROBLASTIC ANEMIA
HEMOGLOBINOPATHY
Lead intoxication
Drugs
Thalassemia
Hgb E, C

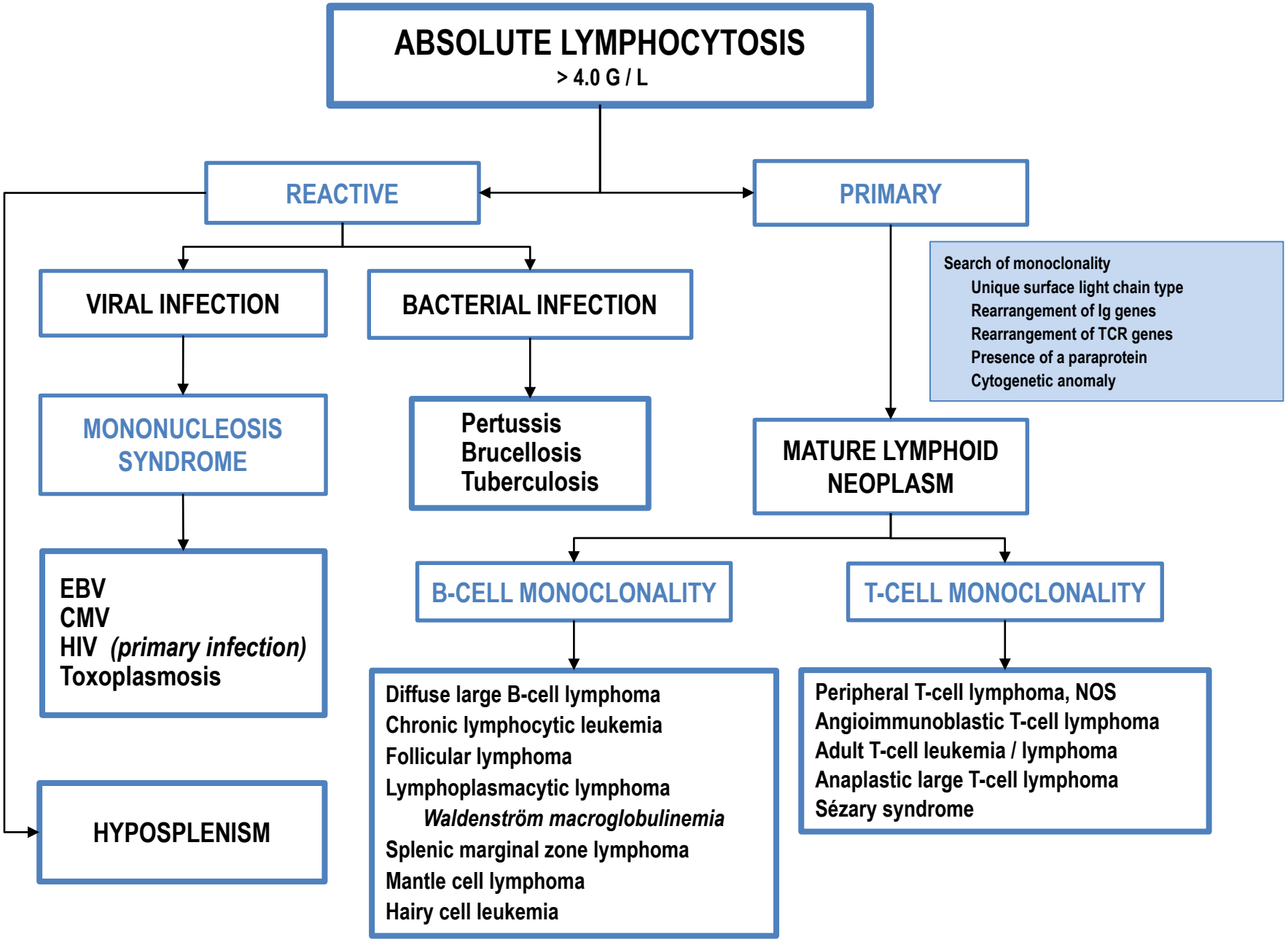

④
MACROCYTIC ANEMIA
RBC morphology
Dosage of vitamin B_{12} and serum folates
Replacement therapy test :
1 mg B_{12} IM / qd
3 mg Folates p.o. / qd
Reticulocyte crisis
(from day 4)
No reticulocyte crisis
VITAMIN B_{12} DEFICIENCY
FOLATE DEFICIENCY
FOLATE and / or VITAMIN B_{12} DEFICIENCY
FOLATE and VITAMIN B_{12} NORMAL
Gastric malabsorption
Achlorhydria
Pernicious Anemia
Intestinal malabsorption :
Gluten enteropathy
Crohn disease
Fish tapeworm[1]
Malnutrition
Increased demand (pregnancy)
Drugs
Alcoholism
Deficiency associated with:
Bone marrow infiltration[2]
Inflammatory syndrome
Alcoholism
Hypothyroidy
Myelodysplastic syndrome[2]
[1] Diphyllobothrium latum
[2] Indication for bone marrow examination :
Cytology
Histology
Immunologic markers
Cytogenetics
Molecular biology

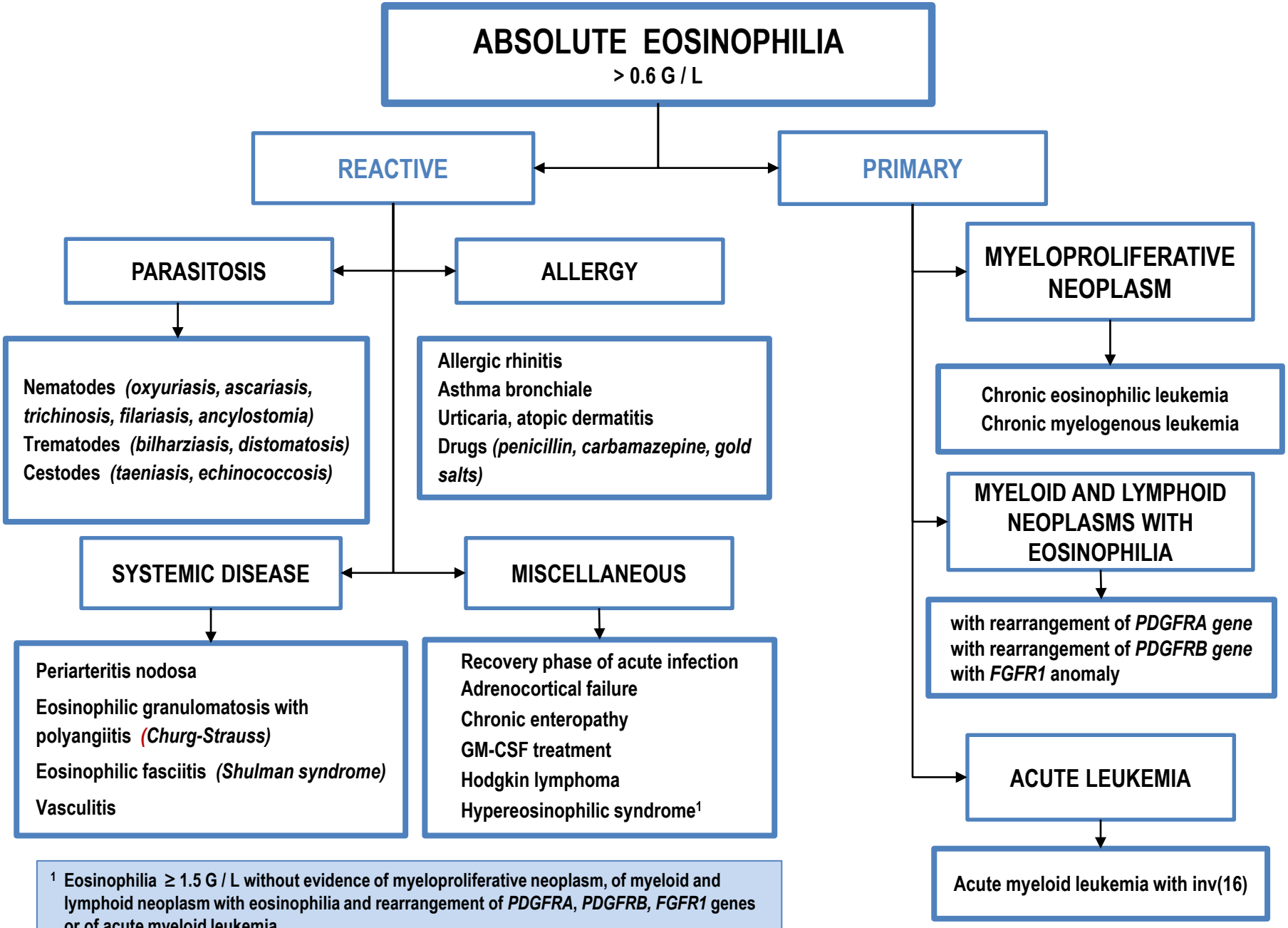

5
REGENERATIVE ANEMIA
(Reticulocytes ≥ 120 G / L)
History
Digestive workup
Gynecologic workup
Bilirubin ⇗
LDH ⇗
Haptoglobin ⇘
ACUTE BLEEDING
HEMOLYTIC ANEMIA
CORPUSCULAR
EXTRACORPUSCULAR
MEMBRANE DISORDER
Hereditary spherocytosis
ENZYMOPATHY
Glucose-6-PD deficiency
HEMOGLOBINOPATHY
Sickle cell anemia
History :
Ethnic origin
Family history
Stay / travel in foreign country
Transfusions
Pregnancies
RBC morphology :
Spherocytes
Schistocytes
Drepanocytes / sickle cells
Coagulation tests (thrombopenia ?)
Examination for parasites
Coombs test, autohemolysis
Hemoglobin electrophoresis
Enzymopathy screening
IMMUNE HEMOLYTIC ANEMIA
TOXIC HEMOLYSIS
Lead intoxication
INFECTIOUS HEMOLYSIS
Malaria
MECHANICAL HEMOLYSIS
Microangiopathy


ERYTHROCYTOSIS
Hgb > 185 g / L (♂) Hgb > 165 g / L (♀)
TRUE
"FALSE"
Dehydratation
Gaisböck syndrome
Heterozygous thalassemia
(microerythrocytosis)
JAK2 V617F mutation
Erythropoietin (EPO) serum level
V617F + EPO ⇘
V617F – EPO ⇘
V617F + EPO no / ⇗
V617F – EPO no / ⇗
PV VERY PROBABLE
PV POSSIBLE
PV PROBABLE
PV UNLIKELY
BONE MARROW BIOPSY1 (NON MANDATORY)
BONE MARROW BIOPSY1 JAK2 EXON 12
BONE MARROW BIOPSY1 (CONFIRMATION)
+
-
Adequate EPO production
Inadequate EPO production
Stay at high altitude
Respiratory failure
Cyanogen cardiopathy
Smoking (carboxyhemoglobin)
CO intoxication
Sleep apnea
Hemoglobinopathy
Benign tumor (renal cyst, uterine myoma, pheochromocytoma, meningioma, cerebellar hemangioblastoma)
Malignant tumor (liver, kidney, parathyroid)
1 Hypercellularity
Proliferation of megakaryocytes
Reticulin fibrosis

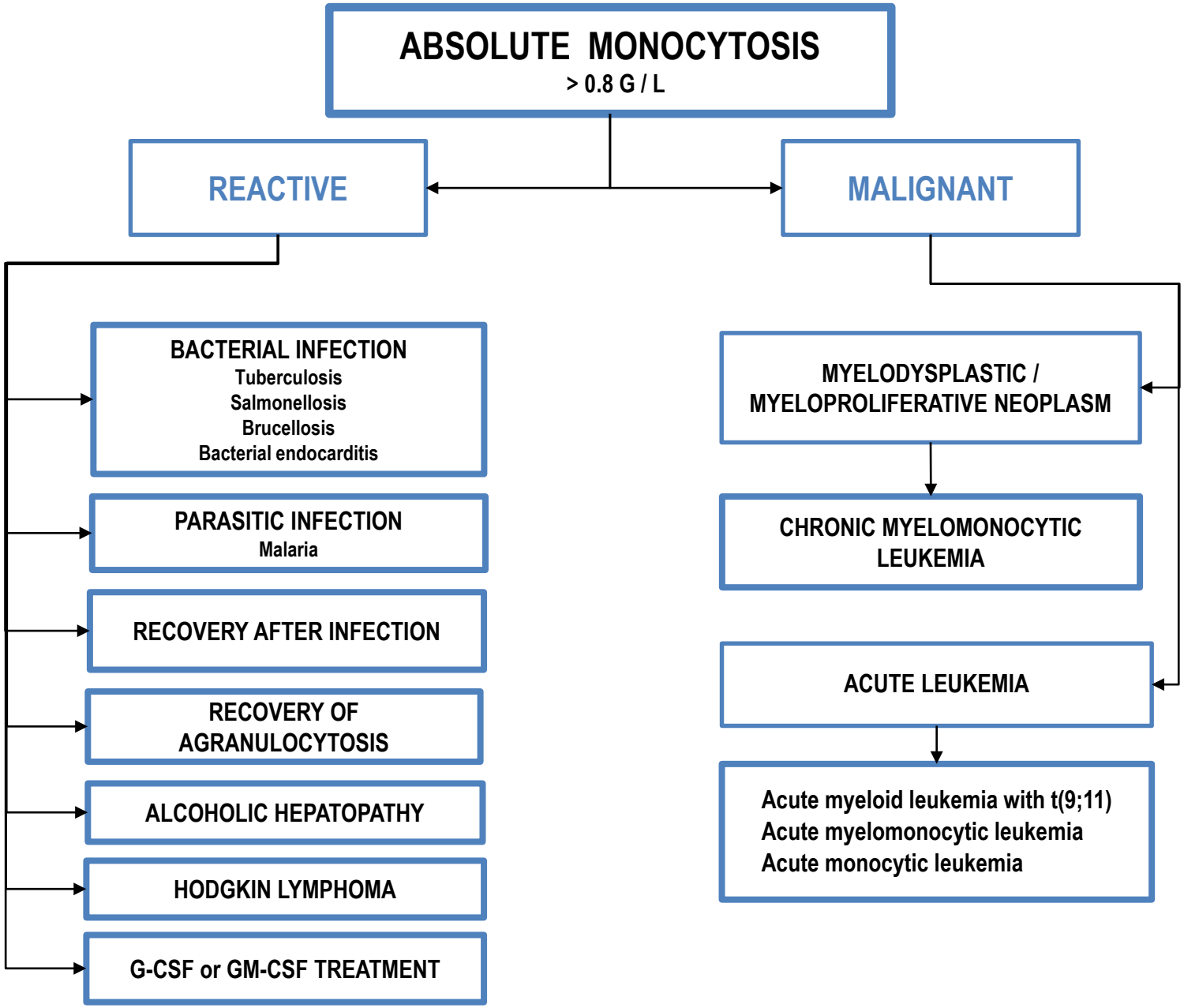

ABSOLUTE NEUTROPENIA
Neutrophils < 1.8 G / L
Agranulocytosis : neutrophils < 0.5 G / L
Postprandial control
CONFIRMED
NORMALIZED
SOLITARY NEUTROPENIA
PANCYTOPENIA
PSEUDONEUTROPENIA BY EXCESS MARGINATION
(fasting patient)
BACTERIAL,VIRAL INFECTION
(salmonellose, brucellose, tuberculose)
CONNECTIVE TISSUE DISEASE
(SLE1)
DRUGS
(Phenylbutazone, Chlorpromazine, Antithyroid)
ETHNIC NEUTROPENIA
CYCLIC NEUTROPENIA
Bone marrow
Splenomegaly ?
B12 / Folates ?
BONE MARROW APLASIA
BONE MARROW INFILTRATION
MYELODYSPLASIA
BONE MARROW FIBROSIS
HYPERSPLENISM
B12 and / or FOLATES DEFICIENCY
1 SLE : Systemic Lupus Erythematosus

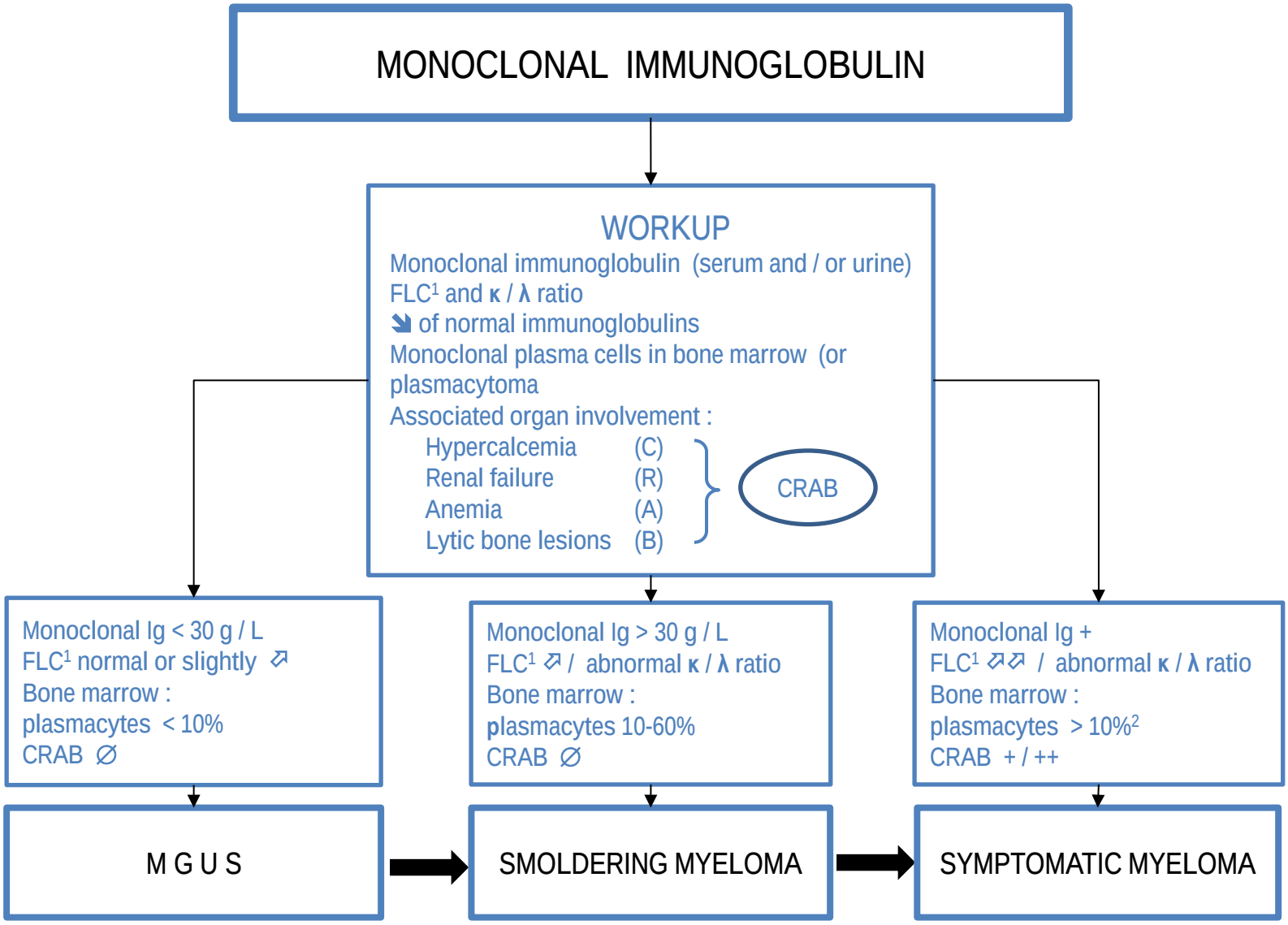

ABSOLUTE NEUTROPHILIA
> 7.5 G / L
REACTIVE
PRIMARY
PHYSIOLOGICAL
PATHOLOGICAL
Neonate
Violent exercise
Menstruation
Pregnancy
Smoking, stress
Inflammatory syndrome
Bacterial infection
Neoplasm
Inflammatory rheumatism
Tissue necrosis
Myocardial infarction
Acute pancreatitis
Drugs
Steroids, Lithium
G-CSF, GM-CSF
Regenerative phase of acute bleeding and of hemolytic anemia
MYELOPROLIFERATIVE NEOPLASM
MYELODYSPLASTIC / MYELOPROLIFERATIVE NEOPLASM
Chronic myelogenous leukemia
Primary myelofibrosis
Polycythemia Vera
Essential thrombocythemia
Chronic neutrophilic leukemia
Chronic myelomonocytic leukemia
Atypical chronic myelogenous leukemia


ABSOLUTE LYMPHOCYTOSIS
> 4.0 G / L
REACTIVE
PRIMARY
VIRAL INFECTION
BACTERIAL INFECTION
Search of monoclonality
Unique surface light chain type
Rearrangement of Ig genes
Rearrangement of TCR genes
Presence of a paraprotein
Cytogenetic anomaly
MONONUCLEOSIS SYNDROME
Pertussis
Brucellosis
Tuberculosis
MATURE LYMPHOID NEOPLASM
EBV
CMV
HIV (primary infection)
Toxoplasmosis
B-CELL MONOCLONALITY
T-CELL MONOCLONALITY
HYPOSPLENISM
Diffuse large B-cell lymphoma
Chronic lymphocytic leukemia
Follicular lymphoma
Lymphoplasmacytic lymphoma
Waldenström macroglobulinemia
Splenic marginal zone lymphoma
Mantle cell lymphoma
Hairy cell leukemia
Peripheral T-cell lymphoma, NOS
Angioimmunoblastic T-cell lymphoma
Adult T-cell leukemia / lymphoma
Anaplastic large T-cell lymphoma
Sézary syndrome



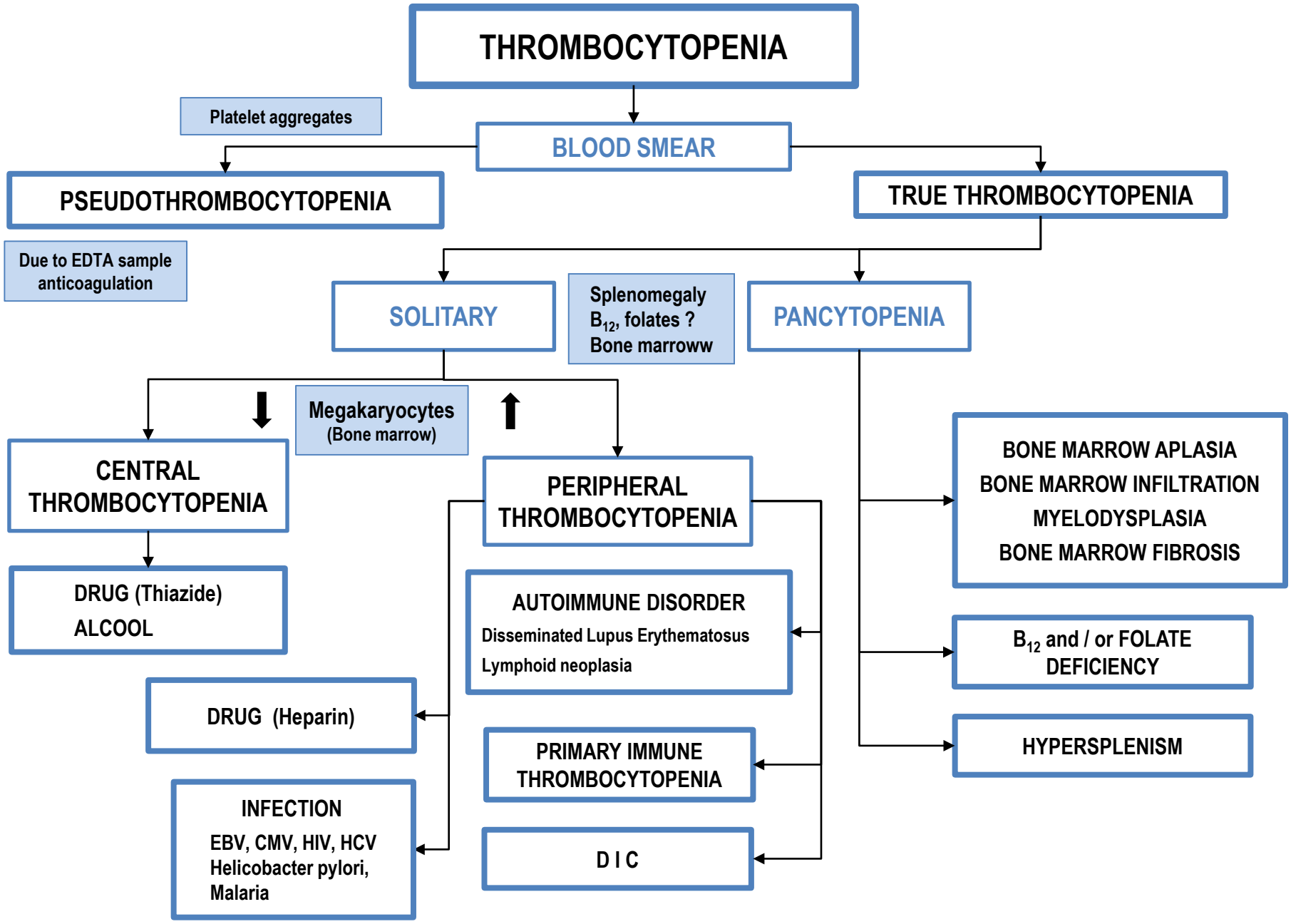
[1] Eosinophilia ≥ 1.5 G / L without evidence of myeloproliferative neoplasm, of myeloid and lymphoid neoplasm with eosinophilia and rearrangement of *PDGFRA*, *PDGFRB, FGFR1* genes or of acute myeloid leukemia

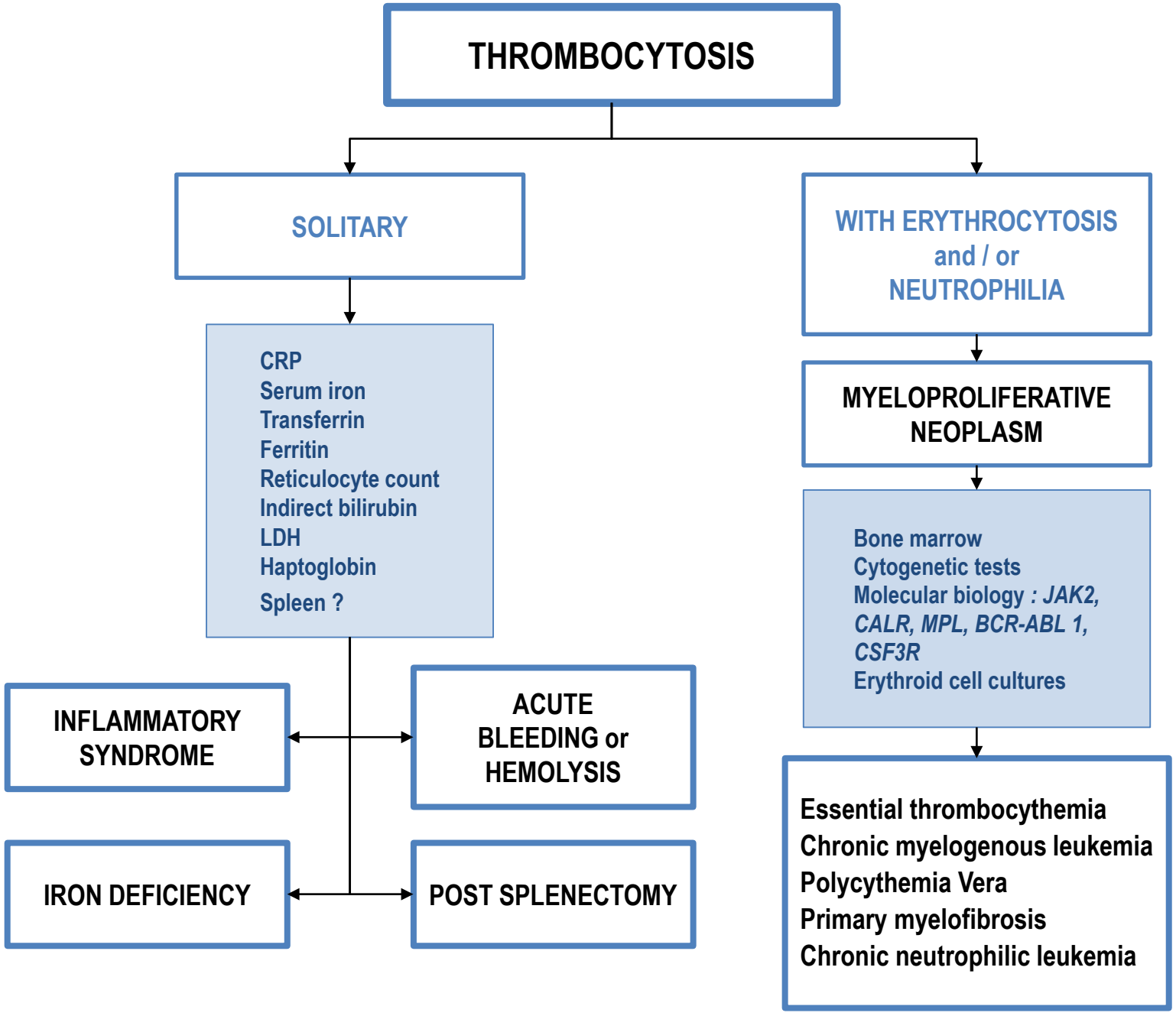

ABSOLUTE MONOCYTOSIS
> 0.8 G / L
REACTIVE
MALIGNANT
BACTERIAL INFECTION
Tuberculosis
Salmonellosis
Brucellosis
Bacterial endocarditis
PARASITIC INFECTION
Malaria
RECOVERY AFTER INFECTION
RECOVERY OF AGRANULOCYTOSIS
ALCOHOLIC HEPATOPATHY
HODGKIN LYMPHOMA
G-CSF or GM-CSF TREATMENT
MYELODYSPLASTIC / MYELOPROLIFERATIVE NEOPLASM
CHRONIC MYELOMONOCYTIC LEUKEMIA
ACUTE LEUKEMIA
Acute myeloid leukemia with t(9;11)
Acute myelomonocytic leukemia
Acute monocytic leukemia

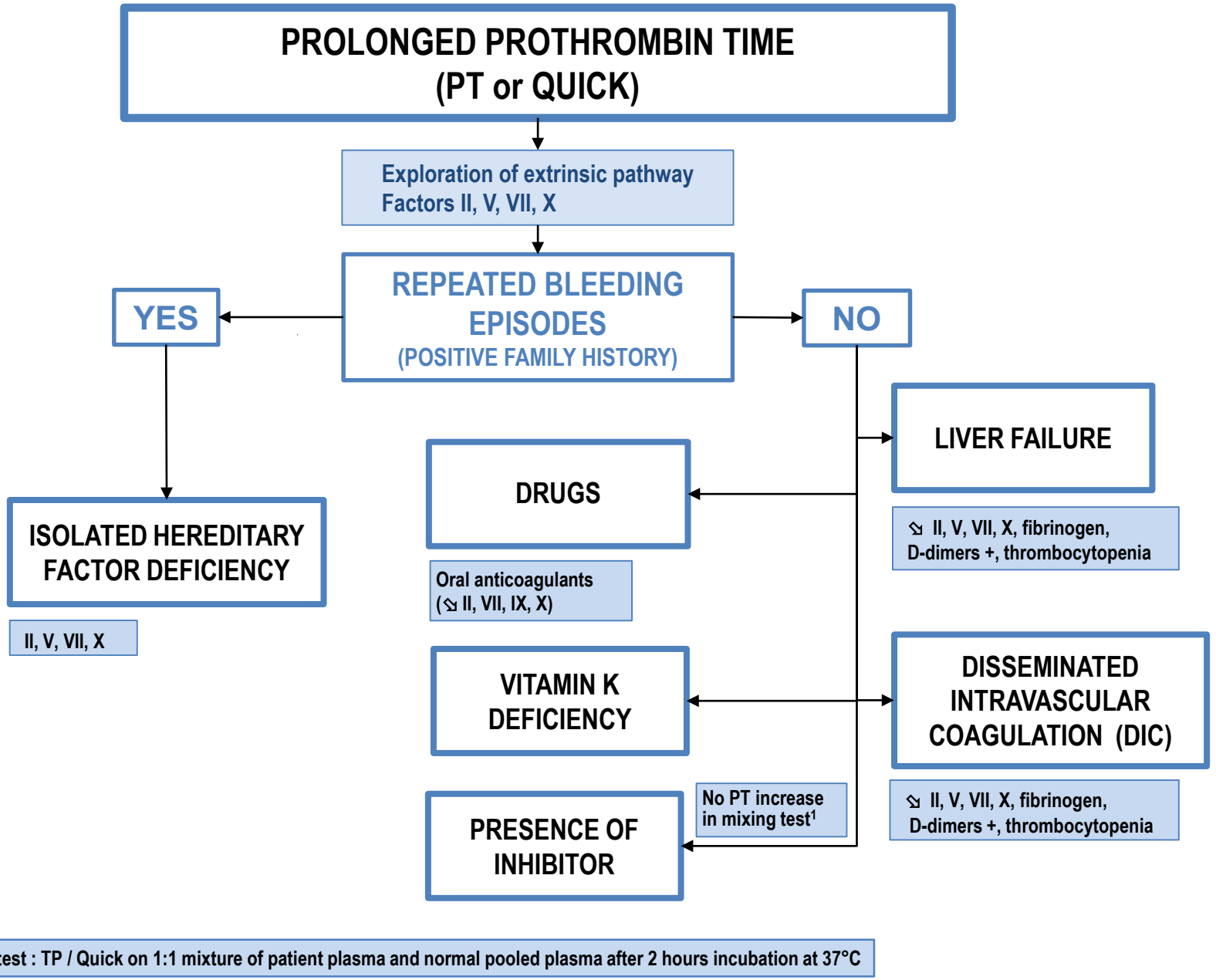


[1] FLC : Free Light Chains *(monoclonal)*

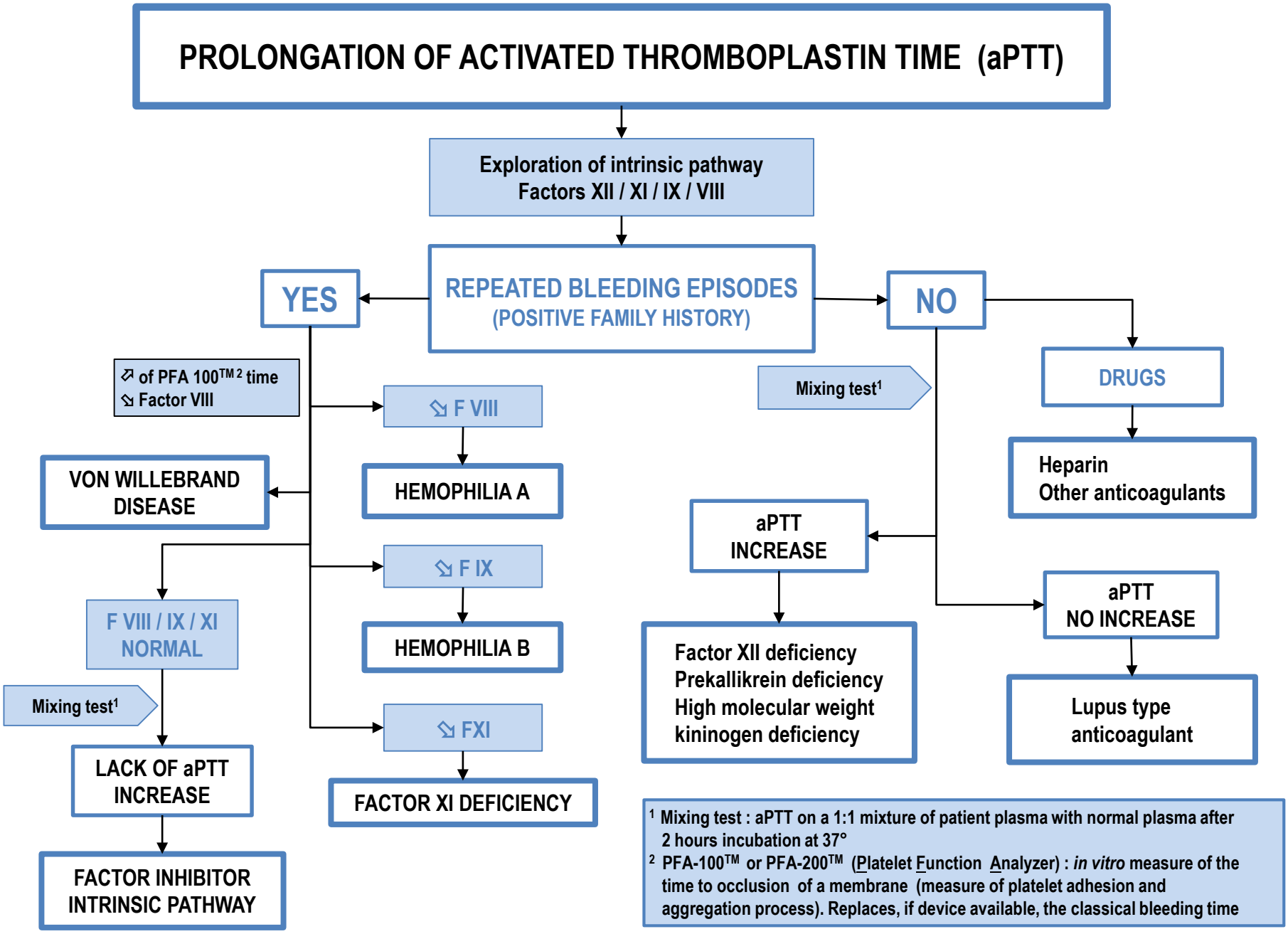
[2] Clonal plasmocytosis > 60% or pathological light chain / normal chain ratio > 100 or > 1 bone lesion on MRI is a sufficient diagnostic criterion


THROMBOCYTOPENIA
Platelet aggregates
BLOOD SMEAR
PSEUDOTHROMBOCYTOPENIA
Due to EDTA sample anticoagulation
TRUE THROMBOCYTOPENIA
SOLITARY
Splenomegaly
B12, folates ?
Bone marroww
PANCYTOPENIA
Megakaryocytes
(Bone marrow)
CENTRAL THROMBOCYTOPENIA
PERIPHERAL THROMBOCYTOPENIA
DRUG (Thiazide)
ALCOOL
AUTOIMMUNE DISORDER
Disseminated Lupus Erythematosus
Lymphoid neoplasia
DRUG (Heparin)
PRIMARY IMMUNE THROMBOCYTOPENIA
INFECTION
EBV, CMV, HIV, HCV
Helicobacter pylori,
Malaria
D I C
BONE MARROW APLASIA
BONE MARROW INFILTRATION
MYELODYSPLASIA
BONE MARROW FIBROSIS
B12 and / or FOLATE DEFICIENCY
HYPERSPLENISM


THROMBOCYTOSIS
SOLITARY
WITH ERYTHROCYTOSIS and / or NEUTROPHILIA
CRP
Serum iron
Transferrin
Ferritin
Reticulocyte count
Indirect bilirubin
LDH
Haptoglobin
Spleen ?
MYELOPROLIFERATIVE NEOPLASM
Bone marrow
Cytogenetic tests
Molecular biology : JAK2, CALR, MPL, BCR-ABL 1, CSF3R
Erythroid cell cultures
INFLAMMATORY SYNDROME
ACUTE BLEEDING or HEMOLYSIS
IRON DEFICIENCY
POST SPLENECTOMY
Essential thrombocythemia
Chronic myelogenous leukemia
Polycythemia Vera
Primary myelofibrosis
Chronic neutrophilic leukemia



[1] Mixing test : TP / Quick on 1:1 mixture of patient plasma and normal pooled plasma after 2 hours incubation at 37°C


PROLONGATION OF ACTIVATED THROMBOPLASTIN TIME (aPTT)
Exploration of intrinsic pathway
Factors XII / XI / IX / VIII
REPEATED BLEEDING EPISODES
(POSITIVE FAMILY HISTORY)
YES
NO
⇗ of PFA 100™ 2 time
⇘ Factor VIII
⇘ F VIII
HEMOPHILIA A
VON WILLEBRAND DISEASE
⇘ F IX
HEMOPHILIA B
F VIII / IX / XI NORMAL
Mixing test1
LACK OF aPTT INCREASE
FACTOR INHIBITOR INTRINSIC PATHWAY
⇘ FXI
FACTOR XI DEFICIENCY
Mixing test1
DRUGS
Heparin
Other anticoagulants
aPTT INCREASE
Factor XII deficiency
Prekallikrein deficiency
High molecular weight kininogen deficiency
aPTT NO INCREASE
Lupus type anticoagulant
1 Mixing test : aPTT on a 1:1 mixture of patient plasma with normal plasma after 2 hours incubation at 37°
2 PFA-100™ or PFA-200™ (Platelet Function Analyzer) : in vitro measure of the time to occlusion of a membrane (measure of platelet adhesion and aggregation process). Replaces, if device available, the classical bleeding time

BY WAY OF CONCLUSION

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Transfusion Medicine is presently not covered in this synopsis

Related morphological inconography may be found on :

http://ashimagebank.hematologylibrary.org

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